HALF WAY SERVICES FOR FORMER MENTAL PATIENTS AND THEIR RELATIONSHIP TO THE CHURCH

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CHAPTER I

INTRODUCTION

> You cannot get away from the accumulated suffering of mankind, or shake off the lesson that it should teach us. And that lesson is that what goes on in my neighbor's house concerns me. If I let him go in need, I too may want. If he has an enemy, he will require me as a friend. If Nature is unkind to him, then I must be kinder. These are all simple things, known from time immemorial to any villager.[1]

I. STATEMENT OF THE PROBLEM

In the year, 1955, the cost to the public for the care of the mentally ill in local, state, and federal institutions in the United States was over one billion dollars. If construction costs for new hospitals, loss of the patients' earning power and loss of tax revenues are included, the cost rises to three and one-half billion dollars.

There is a need for twenty thousand new psychiatrists per year. The present net gain of psychiatrists is only four hundred per year.[2] In addition seventy-four per cent of the mental institutions of our nation are overcrowded and forty per cent of the beds are obsolete and

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[1]Donald C. Peattie, Immortal Village; in Harry A. Wilmer, Social Psychiatry in Action (Springfield, Ill.: Thomas, 1958), p. 2.

[2]Wilmer, op. cit., pp. 5-6.

deteriorated. There are about 750,000 patients in mental hospitals in the United States. The annual admission rate of patients to these hospitals is fifteen thousand per year. They occupy one out of every two hospital beds.[3] On the basis of current admission statistics, one out of every ten persons will spend some part of his life in a mental hospital.[4]

Once hospitalized, the patients find the programs of the institution are focused on sending them back into the community as soon after admittance as possible. New drugs, more humane treatment, and improved psychotherapeutic methods move the patient more quickly toward this goal.[5] Where do the patients go when they are released? Some return to their families; others, having adequate finances, settle in a new community and form new friendships. Still others, having neither adequate finances, nor a family who cares, face a future that seems hopeless. Entering the community alone can easily become overwhelming for the recently released patient. The released mental patient faces the

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[3]Otto Von Mering and Stanley H. King, Remotivating the Mental Patient (New York: Russell Sage Foundation, 1957), pp. 19-20.

[4]Wilmer, op. cit., pp. 5-6.

[5]Price Cobbs, "Why Halfway Houses?" in Glide Urban Foundation, Specialized Housing for Young Adults (San Francisco: 1964), p. 3.

difficult requirements of daily living. He may face intolerance on the part of the community. He may suffer insensitivity toward his fears. His closest relatives may ostracize him.

Facing these pressures, the former patient's self confidence can easily collapse. Then, once again, he may require the safety of the institution. Patricia Gumrukcu, a sociologist and psychiatric half way house director, says: "the isolate, the patient in California who comes back from a state hospital and lives alone and outside the family group returns to the hospital within a year in 40-43% of the cases."[6]

These facts raise serious problems for states, communities, and individuals in their facing of mental illness. What can be done in the community to help the former mental patient remain out of the hospital? What can be done to serve those persons who are emotionally disturbed but, as yet, do not need hospitalization? Half way services provide a hope to these persons by offering a semi-structured, semi-protected bridge between remaining in the hospital or being forced to live directly with the community.

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[6]Patricia Gumrukcu, "Is There More Than One Way," in Glide Urban Foundation, op. cit., p. 39.

Under investigation in this study, therefore, will be half way services for former mental patients and their relationship to the church. Two questions will underly the research: How can half way programs serve as social therapies for former mental patients? How can the church be related to them?

II. DEFINITIONS AND LIMITATIONS

In this study, the term, "half way services," will be defined as the services and programs that provide either social, vocational, or residential bridges that help the former mental patient make the difficult transition between the sheltered environment of the hospital and the rigorous life of the community.

In the literature available on half way services, the term, " half way houses," is often used interchangeably with the term, "half way services." Henry Wechsler, a social psychologist at Harvard University, defines half way house as a bridge or transition between the hospital and community.[7] He recognizes, however, that other writers narrow it to a residential setting. He says:

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[7]Henry Wechsler; in Patricia Gumrukcu, "Mostly in the Last Ten Years," in Glide Urban Foundation, op. cit., p. 14.

> "On the most obvious level the half way house provides a residence for mental patients who no longer need to remain hospitalized, but are as yet unable to establish independent residence in the community."[8]

Another writer acknowledges this narrower interpretation but broadens the meaning of half way house to include the social clubs and vocational shops that provide programs for the former mental patient.[9]

In this study, the term "half way services," will be used in place of "half way houses" to avoid this confusion of terms. The term, residential half way house, will be used when refering to a service that provides living arrangements for the former mental patient. Half way services will include the social, vocational, and residential bridges between the sheltered environment of the hospital and the rigorous life of the community.

This study will limit itself to half way services for former mental patients, who were hospitalized with a psychosis. Half way services for persons hospitalized mainly for anti-social behavior (socio-pathic) such as alcoholism, sexual deviation, and drug addiction will not be in the scope of this paper. This is not to say mental illness may not be involved. It is rather to realize that

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[8] Ibid., p. 14.

[9] Gumrukcu, "Mostly in the Last Ten Years," in Glide Urban Foundation, op. cit., pp. 12-13.

the personnel of many psychiatric half way services refer to other agencies, those whose basic problem is of a sociopathic nature. These personnel feel specific services are needed for those with a particular sociopathic problem.[10]

III. A RESUME OF PREVIOUS INVESTIGATIONS

Most of the researched information had to be gathered from brief paragraphs in books and short articles in periodicals. The literature lacked a comprehensive study of half way services. As we look at previous investigations, David Landy reveals that:

> The research minded reader will no doubt by this point wonder about the relative lack of specific, verifiable studies of the effectiveness of these studies...An extensive survey in 1955 disclosed a startling scarcity of careful objective studies of the exploratory or experimental variety and a reliance on untested impressions of proof.[11]

Patricia Gumrukcu concurs in this when she says:

> There is a dilemma in doing research in a psychiatric half way house...; Particularly if research includes the label of 'demonstration', the researcher is committed to do two things, sometimes simultaneously. He is demonstrating, that is showing, and he

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[10]Brete Huseth, "England's Halfway Houses," Mental Hospitals, XIII (August 1962), 422-424; David Landy, "Rutland Corner House: A Case Study," Journal of Social Issues, XVI (April 1960), 27-32.

[11]David Landy and Henry Wechsler, "Common Assumptions, Dimensions and Problems of Pathway Organizations," Journal of Social Issues, XVI (April 1960), 72-73.

> is researching or finding out. This creates limitations to experimentation... In other words, we do, before we question how we should do... And since the half way house is a new movement in the field of social science, perhaps at this point we should focus more on describing rather than attempting pure research.[12]

Investigations and research available, however, have proved unequivaqually that half way services for the mental patient are a necessary and growing movement in our society.

IV. SOURCES OF DATA

The major resources for this research were books, journals, and personal visits to various psychiatric half way programs, such as Baker Place in San Francisco and Recovery, Incorporated in the Los Angeles area. Three months were also spent in clinical pastoral training at Patton (California) State Hospital, a psychiatric hospital. This provided an opportunity to become involved in listening to the patients' hopes and fears and sharing with them.

Another experience that provided resource material was that of leading groups of lay people in sensitivity training at the First Christian Church of Fullerton, California. Some problems of personal involvement with the mentally ill in the community were shared. Some of the

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[12]Gumrukcu, "Is Service Enough?," in Glide Urban Foundation, op. cit., p. 25.

group members are continuing to explore the possibilities of involvement in a psychiatric half way service.

V. ORGANIZATION OF REMAINDER OF THE DISSERTATION

In Chapter II the background of the half way services will be presented showing the inception of this movement and its growth both in scope and in experience through history.

In Chapter III, the various types of half way services will be explored. These will include the social, vocational, therapeutic day care, and residential services.

In Chapter IV, a social club, Recovery, Incorporated, and a residential house, Baker Place, will be explored in detail.

Chapter V will present some issues that are involved in relating half way services to the church. Attitudes and presuppositions of the mental patient and the church member will be presented.

In Chapter VI, the role of the church in the half way movement will be explored. Practical ways in which a church fellowship can become involved in half way services to the community will be presented.

CHAPTER II

A HISTORY OF THE HALF WAY MOVEMENT

Looking backward into history, one discovers very few programs that provided half way services for the mentally ill after their release from the hospital. It was not until the 14th century that a few hospitals even provided humane treatment.[1] Hospitals for the mentally ill were seen as places of no return. Patients were seen as incurable. Rehabilitation was seen as impossible! A rapid development in half way programs and philosophy did not begin until A.D. 1950. The half way program therefore, is mainly of recent origin.

I. HALF WAY SERVICES BEFORE A.D. 1900

In Leviticus 35:11, it has been discovered that cities of refuge were set aside to afford sanctuary for unintentional murderers seeking escape from the swift retaliation of the deceased's family. In Numbers 35:11, it says: "Then you shall select cities to be cities of refuge for you...". The creation of these cities laid a mood and

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[1]Price Cobbs, "From Snake Pit to Modernity," in Glide Urban Foundation, Specialized Housing for Young Adults, (San Francisco: 1964), p. 3.

foundation that would later usher in half way services. These cities stood as places of asylum half way between execution and freedom. "Among many peoples of antiquity... certain shrines or sacred precincts were regarded as providing absolute security to fugitives. Innocent and guilty passed beyond the reach of revenge."[2]

Immediately upon the fugitives arrival in a Hebrew city of refuge, the elders passed upon his right of asylum. Later, the entire congregation tried the fugitive. If he was found innocent, he remained in the city until the high priest's death.[3] The question can be raised as to whether the mentally ill ever committed a crime and therefore used these cities of refuge as temporary sanctuaries. If they did, it would most likely not be recorded as mental illness. "The O.T. contains very few references to actual insanity or mental disease as such, despite its prevalence in the ancient Near East."[4] The reason for this seems to be due to the fact that "deficiencies of motive or deranged states of mind were often expressed in terms of cardiac dysfunction or pathology."[5]

From this information the inference is drawn that some mental patients did flee to these cities of refuge.

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[2]Interpreter's Dictionary of the Bible, I (New York: Abingdon Press, 1962), p. 638.

[3]Ibid., p. 639. [4]Ibid., p. 850. [5]Ibid., p. 848.

It is also inferred that these cities provided an early foundation for a more humane concern for the fugitive which later influenced the organizers of half way services.

In the Roman Empire during the second and third centuries after Christ, many Christians reacted against the laxity of member discipline and to internal dissatisfaction with self aroused by the teachings of Jesus. Because of this, many entered monasteries. These monasteries became small communities governed by a head monk and a set of rules. The monasteries were mainly places of isolation. The monks would shun the world outside its walls.[6] This concept of isolation lasted for many centuries. In the 13th century, a great monastic revolution occurred.

> With the opening years of the thirteenth century Monasticism, which had once more passed into a period of decay and death...entered upon the greatest revolution it had as yet experienced. Without changing its basic principle of poverty, celibacy, and obedience it sought to work out its ideals, no longer by shunning men, but by seeking them, following, in this matter, but with greater completeness, the lead already given by the Austin canons, with their attention to education, parish duties, the care of the sick and needy, the building of bridges and the like. The coming of the friars, under the inspiration of St. Dominic and St. Francis was the rise, in fact, of a new conception of Monasticism....[7]

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[6]Kenneth S. Latourette, A History of Christianity, (New York: Harper & Brothers, 1953), pp. 226-227.

[7]Herbert B. Workman, The Evolution of the Monastic Ideal, (London: Epworth Press, 1927), p. 271.

The early monasteries were retreats from the world. The later monastic movement of the friars was "an order of social laborers... They must find their Grande Chartreuse in the wretched slums of overcrowded cities, their mountain-tops of contemplation in the haunts of plague and fever."[8]

Now troubled men would enter the monastery as a half way place for prayerful preparation, only to be sent out into the world of need. As Gumrukcu says: "The half way movement existed de facto long before any definition was given."[9]

According to legend, circa A.D. 600, a princess of Ireland fled from her deranged father. He followed her to an area near Geel, Belgium, and there he killed her. In A.D. 900, this princess was canonized and became the patron saint of the mentally ill. Legend speaks of miracle cures in the Geel area. A shrine was erected. Around A.D. 1450, a church was erected and patients waited in the iron barred cells of the church for a cure. The cells soon overflowed. Housewives began to board the patients and soon relatives brought their sick to stay as residents in the Geel

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[8]Ibid., p. 272.

[9]Patricia Gumrukcu, "Mostly in the Last Ten Years," in Glide Urban Foundation, op. cit., p. 11.

Community until they became well. This unique experiment is still in operation.[10]

The first hospital for the mentally ill was opened in England in the thirteenth century. It was named Bethlehem. Through slurred usage the word, bedlam, arose to denote confusion and craziness. Patients were placed in this hospital for removal from society.[11] As previously stated in this chapter, it was not until the fourteenth century that any consideration for humane treatment was given to the patients.[12] The first hospital for the mentally ill in the United States was built in Pennsylvania. It was built far in the country "to deny or ignore the existence of people who deviated."[13]

After hospitals were built to isolate the mentally ill from the community, then attention began to be given to returning these people back into the community. In 1879, a few hostels were organized in England for ex-mental patients. The residents were grouped by age and by the level of expected social and vocational adjustment.[14]

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[10]John D. J. Moore, "Report from Belgium: What Gheel Means To Me," Look, XXV (May 23, 1961), 35-39.

[11]Cobbs, op. cit., p. 3.

[12]Ibid., p. 3.

[13]Ibid., p. 3.

[14]Brete Huseth, "England's Halfway Houses," Mental Hospitals, XIII (August 1962), 422.

II. HALF WAY SERVICES AFTER A.D. 1900

Social clubs. In 1937, Abraham Low, a psychiatrist at the University of Illinois Medical School, formed a group composed of mental patients. The purpose of the group was to prevent relapses in former mental patients and to prevent chronicity in nervous patients. These patients met for weekly group therapy sessions under the guidance of a professional moderator. In 1941 this movement became separated from the hospital. An independent organization, it is now known as Recovery, Incorporated.[15]

In 1940, Joshua Bierer began some ex-patient groups in England. These "Social Therapeutic Clubs" include over two hundred groups. In the United States in 1957, there were about forty-two such ex-patient groups. Three-fourths were established after 1950.[16] Many of these groups use the name "Friendship Club" or "Fireside Club."[17] Some of these will be noted in the next chapter.

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[15] Recovery, Incorporated (Chicago: Recovery, Incorporated, 1962), pp. 3-4.

[16] Henry Wechsler, "Halfway Houses for Former Mental Patients: A Survey," Journal of Social Issues XVI (April 1960), 47.

[17] Maurice Jackson, "A Directory of Therapeutic Self Help Groups," Their Brother's Keepers (Berkeley: Berkeley Baptist Divinity School, 1962), pp. 6-11. (Mimeographed.)

Vocational workshops. Vocational workshops for the employment of the handicapped had their origin in the United States. They began with "the establishment by the Perkins Institution and Massachusetts School for the Blind in 1840 of a workshop designed to provide a protective outlet for the abilities and aspirations of its former pupils."[18]

These workshops for the blind were the forerunners of workshops for other kinds of handicaps, such as mental illness. Often called sheltered workshops, these "Special workshops for the handicapped...emerged to positions of prominence in rehabilitation shortly after the first World War. They assumed various forms, depending upon the purposes for which they were designed."[19]

The growth in sheltered workshops at this particular time was due to the expression of a revolutionary new concept. During the late 19th century, employment of the handicapped functioned under the concept that the handicapped were essentially wards of the workshop. They were considered incapable of independence and the ability to exercise personal responsibility. In the early 20th

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[18]Peter J. Salmon and Harry J. Spar, "Historical Development of the Special Workshop," Workshops for the Disabled (Washington: Department of Health, Education, and Welfare), p. 135.

[19]Ibid., p. 136.

century, however, this concept was radically altered.[20] The motivating objective for any service of rehabilitation was "the objective of providing service not alone for its mitigating effects but, even more importantly, for its strength-giving and independence-inspiring effects."[21] In 1954, the Vocational Rehabilitation Act was passed. This legislation provided funds for the building, equiping and staffing of rehabilitation facilities. Workshops grew rapidly.

In 1965, the Senate committee on labor and public welfare supported a bill of amendments to the Vocational Rehabilitation Act. This new bill provides funds for construction and staffing of public or non-profit workshops. It helps economically impoverished states for the Federal Government will match funds with the State on a sliding scale.[22]

Until recently, most vocational workshops like Goodwill Industries and Easter Seal Training Workshops, served only the physically handicapped. As employers, the staff of these physical handicapped workshops felt the worker with emotional problems would upset the other

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[20] Ibid., p. 136. [21] Ibid., p. 136.

[22] National Association for Retarded Children, New York. Children Limited, XIV:2 (April 1965), 1.

workers. They felt the emotional patient was unpredictable. The staff also felt many of the workers with emotional problems could not be as productive as the workers with physical handicaps.[23] With the lead of the State Vocational Rehabilitation Services, this concept is changing. The emotionally handicapped as well as mentally retarded, are being worked into the program. Former mental patients who can be helped by the workshop are being placed with the mentally retarded, cerebral palsied, and physically handicapped.[24]

There are only three sheltered workshops (in the U.S.) specifically formed for the emotionally disturbed. One of these is Napa State Hospital in Imola, California. It was founded in 1953 and provides homebound employment and training in personal adjustment. Vincennes Manor, Incorporated is the second sheltered workshop. It was founded in 1960 in Chicago, Illinois. The workshop provides occupational therapy for its twenty clients. The Work Therapy Center in Chicago, Illinois was formed to serve the emotionally disturbed but accepts a few other

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[23]Joan F. Murray, "An Experiment in Changing the Attitudes of Employers toward Mental Illness," Mental Illness XLII (July 1958), 405-406; Simon Olshansky, "The Transitional Sheltered Workshop: A Survey," Journal of Social Issues (April 1960), 36-37.

[24]Office of Vocational Rehabilitation, Directory of Workshops for the Handicapped (Washington: 1961), pp.1-10.

handicapped persons. Founded in 1961, it serves twenty-two clients. The workshop provides training in personal adjustment and an evaluation of the patient's progress and needs.[25]

Day treatment centers. The first day treatment hospital for outpatients opened in 1932 in Moscow, Russia.[26] It served outpatients with medical problems who were well enough to leave the hospital while still requiring some weekly medical care. In 1935, another treatment center called Adams House was opened by a Dr. Woodhall in Boston, Massachusetts. In 1938, Dr. Helen Boyle opened a center at Chichester Hospital in England. These centers served persons who needed partial medical care.

The success of these centers influenced the opening of psychiatric outpatient centers. The first day care hospital for the psychiatric patient was organized in 1946 by a Dr. Cameron at Allen Memorial Institute of McGill University, Montreal, Canada. It was here that the title, "day treatment center" originated.[27]

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[25]Ibid., pp. 10, 31-32.

[26]Charles Winick, "Psychiatric Day Hospital: A Survey," Journal of Social Issues XVI (April 1960), 8.

[27]Thomas Boag, "The Day Hospital," Workshop on a Broad Integrated Program of Mental Health Services in an Urban Community (Hartford: Connecticut State Department of Mental Health, February 1961), p. 44.

Residential houses. A residential house is a home where released mental patients can reside for a few months before returning to live by themselves in the community. In 1960 there were seven residential houses in operation in the United States. They were all founded after 1954. Three of these houses were organized by the Division of Vocational Rehabilitation, State of Vermont. Two of these houses are for women, one in Montpelier and the other in Burlington, Vermont. The third house is for men and is located in Burlington. In the Los Angeles, California area, the local Veteran's Administration organized Portal's House. Its residents are all male. Quarter's House in San Jose is for male residents from a state hospital. Rutland Corner House in Boston, Massachusetts is the sixth house formed. This house will be presented more fully in a later chapter. Woodley House in Washington, D.C., was formed in 1959 by a private group under the direction of Joan Doniger. Miss Doniger is director of the house. An eighth house, Modesto House of California, was closed in 1956. Apparently this was due to a shortage of funds.[28]

By 1964 the number of these houses had advanced to forty. About twenty-five percent of these houses were originated by pioneers such as Joan Doniger of Woodley

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[28]Wechsler, op. cit., pp. 20-21.

House in Washington, D.C. The remainder of the residential houses have been formed by the Veteran's Administration.[29]

At present, Vermont is attempting a network of half way residential houses as part of a coordinated program between rehabilitation agencies and the state mental hospitals.[30]

Conclusion. The resent rapid development in the growth of half way services seems to be due to changing concepts of the psycho-therapeutic sciences. The old concept was to remove people from the community and isolate them. The new trend is to release people from the hospital as quickly as possible so they can return to the community. This helps prevent the chronicity that occurs in long hospital stays. The new trend also allows the patients to continue their relationships as soon as possible after hospital admittance. This is accomplished through family therapy sessions, special social events, and special persuasion to the family on the importance of family visits. Therefore, the fear of a long stay and removal from the outside community is kept at a minimum. Tranquilizing drugs have also played a prominant part in shortening the patient's stay.

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[29]Gumrukcu, op. cit., p. 15.

[30]Wechsler, op. cit., p. 21.

The hospitals are being seen as therapeutic communities. Maxwell Jones spoke of "making the hospital into a more real community type organization, including everyone who worked with the patient as part of the rehabilitation environment."[31] The more normal the environment within the hospital area, the easier adjustment should be realized outside.

At Patton State Hospital in California, this concept is being stressed. Some of the staff wear street clothes. There is an athletic field and a farm. On Thursday night, major movies are shown. A miniature golf course has recently been completed.

This concept of the therapeutic community has now broadened to include the society outside the hospital. The hospital personnel are now calling upon this society to provide more half way services such as outpatient clinics, family care homes, and residential houses. It is hoped that more and more communities will respond and inaugerate similar programs.

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[31]Maxwell Jones; in Gumrukcu, op. cit., p. 11.

CHAPTER III

THE TYPES OF HALF WAY SERVICES

Most psychiatric half way services are organized according to the primary function they provide the former patient. The social clubs have have leisure time activities and patient identification as their primary functions. Vocational services are organized to provide former mental patients with remunerative employment and job skills. The day care centers provide intensive therapy while allowing the former hospitalized patient to live at home and be active in his community. The residential houses offer half way living accommodations while the former patient adjusts to life in society and prepares to live in the community by himself.

If one word were needed to describe the main purpose of a half way service, it would be "rehabilitation." Rehabilitation has been defined as "the process of restoring the disabled to optimal physical, mental, social, vocational, and economic usefulness."[1] A more precise definition of rehabilitation is:

> A dynamic process of reestablishment of the disabled person's capacity to sense and participate in his environment and communicate with others; to adapt

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[1]Public Health Service, Areawide Planning Facilities for Rehabilitation Services (Washington: April 1963), p. viii.

> to the physical world, which includes ability to tolerate physical energy expenditure while resuming activities of daily living; and to utilize fully his intellectual, social, and vocational potentialities.[2]

Tranquilizing and anti-depressant drugs have greatly aided the patient in rehabilitation. They have helped the patient gain greater control over his moods. They have helped him become a more stable member of society. The next step, in the patient's rehabilitation, is to help him stay well. He must be with a program that allows him to modify his former role of hospital inmate to a normal social role. A bridge must be provided between the hospital and the community.

David Landy, a professor in Public Health at the University of Pittsburgh, sees half way services as fulfilling this process of rehabilitation. He sees within the process two movements which he calls acculturation and socialization. Acculturation is an enforced cultural conformity imposed by a social half way service in bringing the patient "back to normalcy." In this cultural environment, the patient must admit he is ill. As his symptoms lessen, the patient must then accept more satisfactory ways of behaving. Socialization is the learning and relearning of interpersonal behavior in therapeutic and anti-therapeutic situations. Through the models of the

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[2] Ibid., p. 1.

rehabilitator-teachers, the former mental patients learn various forms of acceptable behavior.[3]

Landy and Wechsler state three common assumptions held by most half way organizations. The first assumption is the need for continuity of rehabilitation. Abrupt gaps from the protective hospital environment to the demanding community environment must be avoided. The patient must gradually be placed in a more demanding environment. Secondly they speak of "delaying action-decompression chambers." This provides a milieu that is non-restrictive, non-threatening and hierarchy reducing. This semi-sheltered environment helps the person grow in independence. Finally there is the purpose of socialization and resocialization. The mental patient's social life has been distorted and impaired. These social barriers can be reduced within realistic limits in a group composed of other persons with similar problems and rehabilitative enablers.[4]

Half way services, therefore, are attempts "to establish an environment appropriate to certain stages of

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[3]David Landy, "Rehabilitation as a Sociocultural Process," Journal of Social Issues XVI (April 1960), 3-4.

[4]David Landy and Henry Wechsler, "Common Assumptions, Dimensions and Problems of Pathway Organizations," Journal of Social Issues XVI (April 1960), 70-71.

psychological needs and certain stages of psychological development."[5]

I. SOCIAL CLUBS

Purpose. The social clubs for former mental patients are mainly concerned with leisure time activities and patient identification. These clubs are organized for former patients who feel they are not ready to resume many new or previous social contacts among society. Many of these clubs are called a "Friendship Club" or a "Fireside Club." Most clubs subscribe to the philosophy which says that if you have been ill, you are the most likely candidate to help and support others.

These clubs are formed to help the former patient adjust more easily to satisfactory interpersonal relationships. For many former mental patients it is easier to share with persons who have been through the social stigma of hospitalization. There is a feeling of comradeship. The fear of being discovered by those who would not understand the person's problems, is lessened. This allows the former patient to be less defensive. The clubs provide help in establishing and maintaining adequate social

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[5]Patricia Gumrukcu, "Mostly in the Last Ten Years," Specialized Housing for Young Adults (San Francisco: Glide Urban Foundation, 1964), p. 12.

relationships. Because social failures can contribute to relapses, maintaining social relationships is as important as finding them. In these groups, the person can be accepted without severe judgment. He can gain courage to share himself. In being able to accept himself and be accepted by others, he can better accept others in turn. In this environment, various behavior patterns can be tested to discover which patterns may be harmful and which ones may be helpful in the wider community.[6]

Membership, leadership, and program. These groups do vary in certain aspects of membership, leadership, and program. In regard to membership some groups admit only persons who have been hospitalized. In some cases it must be a specific hospital. Club 103 is only for ex-patients from Boston Hospital. Other groups are composed not only of ex-patients but of those who are struggling with a mental and nervous problem. Recovery, Incorporated is of this type. Some clubs screen prospective members. Those applicants who are incapable of complete management of themselves are referred to other agencies.

Some clubs, like Recovery, insist upon lay leadership. The Fireside Clubs of California, however, use combined lay and professional leadership.

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[6]Henry Wechsler, "The Ex Patient Organization: A Survey," Journal of Social Issues, XVI (April 1960), 49.

The program of some clubs is strictly social. Any discussion of illness or preoccupation with symptoms is avoided. In other groups such as Recovery, discussion of one's illness is encouraged and the use of self help methods stressed.

Louisiana Association for Mental Health: A Club. In 1957 the Louisiana Association for Mental Health organized a club that would accept referrals from hospitals, psychiatrists, and social agencies.[7] They set the age range from twenty to fifty years of age. Alcoholics and sociopathic personalities were referred to other agencies. Those who were accepted had to meet four of six requirements. They were:

a. Is the member in the age range 20-45?
b. Is he potentially employable?
c. Does he represent the white collar, middle class, socio-economic group?
d. Does he have at least a 12th grade education?
e. Has he been hospitalized less than 6 months and on no more than 2 different occasions?
f. Is he currently receiving psychiatric help?[8]

After five years, a study was made to find out what type of ex-patient benefited most, and what the ex-patient saw as the main benefit provided by the club. Out of an

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[7]Mabel B. Palmer and E. Lee Hoffman, "A Study of the Membership and Program of a Club for Ex-patients of Mental Hospitals," Mental Hygiene, XLVIII (July 1964), 373.

[8]Ibid., p. 372.

initial 125 members, 71 were interviewed, the remainder having died, moved, or refused to answer. The age range was twenty to sixty, the median being thirty-five. There were 27 males and 44 females (38 per cent versus 62 per cent). There were 62 per cent living with parents or spouse, 23 per cent were living alone, and the remainder were in boarding homes or with friends. Of those who responded, only 8 per cent felt their present living arrangements were unsuccessful. The others felt they had made an acceptable return to the community.[9] Those contacted according to age groupings are listed below.[10]

		Contacted (per cent)
Sex:	Male	38
	Female	62
Age:	20-29	28
	30-39	39
	40-49	23
	50+	10

The evaluation of the study showed that those people contacted between twenty and forty-five years of age most needed and could most effectively use the social club. Those who were younger or older than this demanded a different program. The fulfillment of social needs depended upon a homogenous grouping as to age, interest, and skill. Of the group contacted, 29 per cent were working and 45

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[9] Ibid., p. 374. [10] Ibid., p. 374.

per cent planned to work soon. This was seen as a healthy sign. The majority of those who were successfully working had previously held jobs of the white collar nature. The less successful at employment never worked or were found in the unskilled laboring class.

The study found that 73 per cent of the members felt the club had been beneficial. Of these, 24 per cent had easily gained confidence. Another 49 per cent had made friends and felt more at ease without having to hide their hospitalization. The study also showed that sixty-nine per cent had found the club a source of activity to learn new social skills and become familiar with community resources.[11] From this study, it was decided that the program should mainly be one of socialization rather than attempting to handle psychiatric problems. The stress is now on gaining confidence, making friends, learning new social skills, and becoming familiar with social resources in the community.[12]

II. VOCATIONAL SERVICES

The half way vocational services are usually called rehabilitation workshops or sheltered workshops. In 1950, the National Committee on Sheltered Workshops and Home-bound Programs defined a sheltered workshop as:

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[11] Ibid., pp. 376-378. [12] Ibid., pp. 376-379.

> A voluntary organization or institution conducted not for profit but for the purpose of carrying out a recognized program of rehabilitation for physically, mentally, and socially handicapped individuals by providing such individuals with remunerative employment and one or more other rehabilitating activities of an educational, psychosocial, therapeutic, or spiritual nature.[13]

These workshops provide vocational training one or more days a week. They focus on rehabilitation through work experience. The workshops provide different types of training. The executive director of the Brooklyn Industrial Home, Peter Salmon, lists the types of training as:

1) Conditioning or training for persons who are psychologically ready for employment and who have no marked remedial disability but who require development in elemental physical abilities.
2) Pre-conditioning or training designed to develop an ability to adhere to a work schedule, to withstand frustration and monotomy, to accept supervision.
3) Reconditioning or training designed to help a handicapped person accept a type of work which is substantially different and which is less rewarding financially or physically than the work he performed prior to the onset of his handicap or the appearance of whatever circumstances may be responsible for his need to abandon the work he prefers or to which he has become accustomed.[14]

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[13]Emil A. Trapani, "General Description of What Workshops Are," Workshops for the Disabled, Rehabilitation Services Series, No. 371. (Washington: Department of Health, Education and Welfare) p. 15.

[14]Peter J. Salmon and Harry J. Spar, "Historical Development of the Special Workshop," Workshops for the Disabled, Rehabilitation Services Series, No. 371. (Washington: Department of Health, Education, and Welfare), pp. 143-144.

Workshops are classified in various ways. Some are classified by the persons they serve, such as the blind, the mentally retarded, or the emotionally disturbed.

Another classification is determined by function. The "industrial workshop" for sheltered employment provides remunerative employment, counseling, and medical service. The people in this type of workshop consist chiefly of those who cannot be absorbed in the competitive labor market. Though they do not need hospitalization they are not able to return to the labor market because of their age or due to their emotional problems. The Goodwill Industries and Workshop for the Blind serve as examples.[15]

The "rehabilitation workshop" provides maximum economic and social rehabilitation through employment. Their prime purpose is to help the handicapped person develop work habits and then place him in competitive industry. Goodwill also serves this purpose. By way of illustration, the Marbridge Ranch in Austin, Texas serves as a rehabilitative half way workshop for retarded young adults.[16]

The "institutional workshop" serves those handicapped persons who are confined to the hospital. This is

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[15]California Senate. Report of the Joint Interim Committee of the California Legislature on the Education and Rehabilitation of Handicapped Children and Adults (Sacramento: January 1959), pp. 141-142.

[16]Ibid., pp. 141-142.

not specifically a half way service. It is listed here for the purpose of showing the three major types of functional workshops.[17] The vocational workshop, therefore, is designed as a half way service that provides special employment opportunities for handicapped persons who, either temporarily or permanently are unable to meet the requirements of fully competitive employment.

Some problems have developed in accepting the former mental patient into a vocational workshop. In some workshops the former mental patient has been viewed with concern and harassed by his non-mentally handicapped co-workers.[18] Another problem has been the goal or purpose of the workshop. The hospital personnel sometimes feel the workshops place business profits before a concern for helping the person grow in skills. They feel the workshops should receive workers with various degrees of skill. The workshops, on the other hand, feel the hospitals generally send them the poorer workers and those who are only partially recovered. They feel the more productive are too often kept in the hospital until they can be sent directly home.

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[17] Ibid., pp. 141-142.

[18] Simon Olshansky, "The Transitional Sheltered Workshop: A Survey," Journal of Social Issues XVI (April 1960), 36-37.

Simon Olshansky, a director at the Cambridge Service for Retarded Children, feels the sheltered shops fit the needs of only a few released psychiatric patients. He feels many are either too sick and therefore resistant to working in a sheltered workshop or are too well and are able to find their own jobs.[19]

III. DAY CARE CENTERS

The day care centers are special therapeutic half way services. These centers allow the patient to live at home while receiving intensive treatment within a relatively structured environment. The patient can be involved with his family and can remain a part of the community. He can commute to the day center for therapy. Dr. Cameron, the founder of the first "day center" located at McGill University in Montreal, Canada, organized it for three reasons.

a. As a new part of an existing hospital where something less than full inpatient admission is desired.
b. As a development from social clubs where it was found desireable to provide more in the way of treatment facilities.
c. As a manifestation in the terminal phases of hospital treatment of inpatients, a sort of weaning process from hospital inpatient service.[20]

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[19] Ibid., pp. 36-37.

[20] Thomas Boag, "The Day Hospital," Workshop on a Broad Integrated Program of Mental Health Services in an Urban Community (Hartford: Connecticut State Department of Mental Health, February 1961), p. 44.

Besides preserving family and community contacts, the day center has been an economy measure. It has required fewer buildings, beds, and meals.[21] Living at home, the former hospitalized patient may visit the day center daily or weekly. Some come for a full day. Others come only for a partial day. Some of the day centers are located on hospital grounds, while others are located in the downtown areas where they are more easily accessible to the patients.

In a New York City program treatment includes social casework, chemotherapy, electroconvulsive therapy, group psychotherapy, and social and vocational rehabilitation. A twenty-four hour emergency psychiatric and ambulance service is provided, and aid can be given in the home. Before the center opened, one-third of all the patients leaving the hospital were returned. Now returns are reduced to ten to twenty per one hundred placements. This can be contrasted with a county wide return of thirty to fifty per one hundred.[22] "Our goal is to aid each patient to identify himself with his home community while gradually withdrawing the clinic from activity on the patient's

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[21] Ibid., pp. 43-44.

[22] Donald M. Carmichael, "New York State Aftercare Clinics in New York City," American Journal of Orthopsychiatry XXXI (July 1961), 642-646.

behalf, but at the same time communicating our continued interest and availability if need should arise."[23]

Charles Winick, research director for the Foundation for Day Hospitals, tells of a study made between inpatient and outpatient costs. The cost per month per inpatient was one-hundred dollars. The cost per month per day patient ranged from eighty to three hundred dollars. At first glimpse the cost seems quite high for a day center. However, the center provides more intensive professional help. The staff consists of a psychiatrist, nurse, recreation instructor, psychologist, social worker and occupational therapist. The program consists of group psychotherapy, pharmacotherapy, and occupational retraining, such as arts, ceramics, and music therapy. The day center also saves on extra beds, meals and building costs. When these added factors are taken into consideration, the day care cost is more economical and provides less social stigma than hospitalization. In this study, patients were selected only if they were well motivated, had family cooperation, could cope with personal hygiene and could provide a minimum of communication.[24]

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[23] Ibid., p. 647.

[24] Charles Winick, "Psychiatric Day Hospital: A Survey," Journal of Social Issues XVI (April 1960), 9-10.

In another study in New York City, 160 patients (49 male, 111 female) were chosen. The age range was seventeen to seventy-one years. The diagnosis was 80 per cent schizophrenic, 20 per cent non-schizophrenic. The patients had been in the hospital between six months and ten years, wither continuously or in several periods of variable duration. They were expected to visit the day center at least once each week. This continued for the first three months. The visits were then reduced to once every two weeks. Finally the visits were made once every month. Vocational needs and close contact with the family received primary attention.

Of those later contacted, seventeen patients remained unemployed, forty-four were gainfully employed (using medication), and forty-five women returned to homemaking (with medication). Undergoing special training for new occupational skills were twelve patients. Out of all of these persons only three were rehospitalized.[25]

IV. RESIDENTIAL HALF WAY SERVICES

In a residential half way service, the living environment is emphasized. In this environment sibling

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[25]Shirley A. Middleton, "After Care," Working Together for Better Mental Health (Columbia: South Carolina Mental Health Commission, October 11, 1961), pp. 32-33.

and family substitutes are provided. There are various types of residential services available.

Family Care Homes

In a family care home, anywhere from one to twelve patients may be integrated into a family unit to give them a sense of family belonging. As for function, there is no clear difference between a family care home and a peer residential house.

A family care home is usually provided by a private family whereas a residential home is staffed and administered by the hospital or agency supporting it. Another difference is that there is usually a wider age range in a family care home.

In one placement agency, psychotic patients were selected for acceptance if it was felt they were not violent and could be comfortable in such a home. Those who because of old age were confused and at times irritable but did respond to individual attention were likewise placed. Finally, the placement agency placed those patients whose recovery the staff felt could be hastened by family care. This included some who had been institutionalized a long time and others who needed to identify with a more healthy family atmosphere.[26]

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[26]Hester B. Crutcher, Foster Home Care for Mental Patients (New York: Commonwealth Fund, 1944), pp. 48-49.

The adult members of a family that opens their home for foster care are called caretakers. Sometimes they are selected haphazardly by foster home placement personnel. In other situations, the caretakers are carefully interviewed for their personal attitudes and emotional capabilities.

When correctly interviewed, sympathy, tolerance, patience, and the lack of being too easily irritated should be sought. Persons who are firm but fair and can lightly pass over unimportant matters possess assets for being caretakers. If a married couple is involved, there should be an emotional balance between the husband and wife. Both should be interested in opening their home for the purpose of providing foster care.[27]

When the prospective caretakers have young children, placement of a discharged mental patient in this home is questionable. The child's imagination may be overstimulated by bizarre behavior. If the caretakers become upset over these events they may insist the patient be returned to the hospital. This could further upset the patient's weak self esteem. On the other hand, the patient may develop a relationship with the child that is therapeutic for patient and child. A grandmother-grandchild relationship could develop. The suitability of placing a patient

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[27]Ibid., pp. 58-59.

in a foster home having young children, depends upon how normal and wholesome the environment has previously been in the foster home. These factors must be considered before placement of a patient.[28]

When the family care homes are located in the country, they are usually called "work house camps." The Gould Farm in Massachusetts, the Spring Lake Ranch in Vermont, and the Meadowlark Homestead in Kansas are representatives of the work house camps. These camps are located in a rural setting, usually on a farm. The patients work at available jobs on the grounds. The daily program is highly routinized. Because of this routine the patients do not get bored. Instead they feel secure with a structured program of responsibility.[29]

In July, 1935, a study was begun of patients sent to foster homes from the Middleton State Homeopathic Hospital in New York. The study was completed in October of 1943. Of forty-eight persons placed in foster homes in 1935, nineteen were still living in the community at the end of the eight year study. Of these nineteen, ten had been discharged from the foster homes and nine were still

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[28]Ibid., pp. 58-59.

[29]Henry Wechsler, "Halfway Houses for Former Mental Patients: A Survey," Journal of Social Issues, XVI (April 1960), 24.

in family care. Of 478 persons placed over the eight year period, 177 or 37 per cent of those placed were adjusting in family care. Over the eight year period over 50 per cent of the patients in the study had made a satisfactory adjustment in family care homes.[30]

Patients at Patton State Hospital have responded both positively and negatively to family care. Most prefer family care to the restriction and isolation of the hospital. Those who do not care for family care generally clarify their feeling by saying they have nothing against such a home but want to be free from any authority connected with the hospital.

The value of family care is summarized as follows:

> "Family care increases the measure of human happiness by restoring to normal life, in a friendly world and often to useful activity, people whom the monotony and frustration of institutional life have reduced at best to passive indolence and at worst to bitterness and rebellion."[31]

Family Care Community

Gheel, Belgium is a unique example of a community that serves the mentally ill. If one passes through the town, he will find the sick working in gardens, riding bikes and sitting in the town square. Young children do

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[30]Crutcher, op. cit., pp. 24-25.

[31]Ibid., p. 9.

not run in fear from the ill and confused. Instead they may take them by the hand and lead them home. A twenty year old schizophrenic girl was starving herself in the hospital and had to be forcibly fed. Since coming to Gheel, she has become neat and friendly and often babysits. The villagers receive only a few francs a day for their care and service, and even this is diminishing. For varied political reasons, Gheel is to be closed as soon as there is more space in other institutions. The hope is that the Gheel idea will survive.[32]

Residential Peer Homes

One of the characteristics of the peer homes is that the age range is usually kept between 20-40 years of age. Another characteristic is that the occupants are expected to terminate their stay within a year after first residency. In the peer home, the residents are urged to work in the community. The programs are less custodial and planned than in family care. There are parties, therapy groups, picnics, and old fashioned conversation gatherings. There is an attempt "to establish an environment appropriate to certain stages of psychological needs and certain stages of psychological development."[33]

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[32]John D. J. Moore, "Report from Belgium: What Gheel Means To Me," Look, XXV (May 23, 1961), 35-39.

[33]Patricia Gumrukcu, "Mostly in the Last Ten Years," in Glide Urban Foundation, op. cit., p. 12.

English hostels. One type of residential peer home is the English hostel. English hostels have been in use for ex-mental patients since 1879. The residents are grouped by age and by level of present and expected social and vocational adjustment. Schizophrenics are considered most suitable. Those referred to other services are sociopaths and epileptics. There are presently forty-two hostels functioning, and of these, twelve are for those between eighteen and fifty years of age. The remainder are for older people who are helped to move into the community but not into jobs.[34]

For ex-patients with a low level of vocational and social adjustment, there are both short term (three to six months) and long term houses.

Tyrwhitt House is a short term house for servicemen who have developed mental disturbances resulting from their service. Some occupational therapy is provided.

Porchester House is another short term house. It is connected with Mapperly Hospital and provides group discussions and some light work projects.

Of the longer term houses, Milner House has a workshop manufacturing electric blankets. Hill House has an intensive program providing graduated work and social retraining.

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[34]Brete Huseth, "England's Halfway Houses," Mental Hospitals XIII (August 1962), 422.

Upon arrival, the resident in such a program works under skilled supervision for six weeks in the workshop, garden, or house maintanence. As his self esteem improves he is allowed to work in the community while living at the hostel. If his work and attitude shows marked improvement he is provided the added incentive of moving to his own personal bedroom.[35]

The homes for residents with a higher level of social and vocational adjustment are short term. The residents must begin work within a month after arrival. The homes have their own cooks. In English houses, the staff eats separate from the patients. The homes have between twenty to forty residents. (In the United States, there are between six and thirty residents.) They feel this is both economical and yet not too large for individual attention. Each bedroom has anywhere from two to seven residents.

Winston House, Fulbourn, Park, and Sunny Corners are shorter term hostels for residents of a higher adjustment level. The rate of readmission to the hospital is under 10 per cent in many houses. This is lower than in the United States, probably because the applicants are required

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[35] Ibid., pp. 422-423.

to have a higher vocational adjustment than is required in most houses in the United States.[36]

Wellmet House. In July, 1960, a group of Harvard University and Radcliffe College students purchased a twelve room house in Cambridge, Massachusetts. It was incorporated as Wellmet House and was to be used as a half way house for former mental patients.

The project grew out of services that had been offered to patients at Metropolitan State Hospital in Waltham, Massachusetts. At this hospital students had been involved in group activities with the patients. Seeing the chronicity of many patients who did not leave the hospital because of regressing dependency, the students decided to take action. A half way house seemed to offer the most needed service to these patients. With the support of the hospital, university, State Department of Public Health, and local mental health associations, they moved into the house with four patients.

The house is a coeducational residence. The students live with the patients, share maintenance, management, and other responsibilities. One aim of the students is to decrease patient apathy and isolation. Another aim is to increase social interaction. An older married couple

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[36] Ibid., pp. 423-424.

was hired to live and work in the house full time. A student manager was selected to direct operations and act as a liason agent with professional consultants and a board of directors. Professional consultants include a psychiatrist, psychologist, and social worker, each of whom visits the house regularly. The board of directors and student members of the corporation are counseled by an advisory board of lay and professional members.

All members living in the house work a fair, if not equal, number of hours on housekeeping chores. Schedules are flexible, however, and if a person is pressed for time, assistance is given. The patient-residents earn money for themselves by doing shirt ironing, typing, and house repair. This work can provide a sense of accomplishment and still be done under reduced social pressure.

Treatment consists of making everyday decisions and performing simple social functions. These social functions include using public transportation, receiving guests, visiting friends at the hospital, and being a member of a cooperative house.

A portion of weekday meetings is set aside for administrative problems. The students serve as role models for the ex-patients. There are also professional consultations and group meetings. There are beach parties, movies, job and clothes shopping trips, and television parties. The reliance is upon unplanned activities.

Each student contributes one-thousand dollars for his own room and board. This is less than in the college dorm. The State Department of Mental Health provides twenty-eight dollars per week for a maximum of three patients. The State Rehabilitation Commission subsidizes an equal number of patients at the rate of twenty-five dollars per week. Private contributions make up the deficit.

The selection of the patient is initially made by a student in the general volunteer program who is assigned to visit a hospital patient for a year. If the patient is selected, the student continues to visit him. Of eight patients who started, three left to live semi-independently and four are now in various stages of rehabilitation.[37]

From experience with various patients, the inconclusive evidence suggests that this particular house has not benefited the overly suspicious person. One such patient was very fearful of responding incorrectly to his demanding involvement and distorted the meaning of many relationships. The staff feels that more patients and time are needed before they make a definite change in the type of resident accepted.[38]

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[37]David Kantor and Milton Greenblatt, "Wellmet: Halfway to Community Rehabilitation," Mental Hospital, XIII (March 1962), 146-150.

[38]Ibid., pp. 151-152.

Conard House. Located in San Francisco, Conard House has an equal number of males and females. The age range is twenty-one to thirty-five. The diagnosis of the residents is 60 per cent schizophrenic, 30 per cent non-psychotic but personality disturbed and 10 per cent marginally retarded. The median education is one year of college. Three-fourths of the residents are single, one-fourth divorced or separated. Of four hundred requests to date, seventy-two have been serviced. The screening interview is considered very important, before accepting or refusing the person. The clinical data is not considered as salient as the individual's personal motivation for being out of the hospital.[39] The staff has found that the most successful residents, in terms of later house and community adjustment took about 1 to 2 months to feel at home. Those who later failed in personal relations and work adjustment felt at home within two to four weeks.[40] For the staff signs of health are seen in growing self-care, employment and social activities.[41]

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[39]Patricia Gumrukcu, "Is Service Enough?" in Glide Urban Foundation, op. cit., pp. 26-27.

[40]Patricia Gumrukcu, "Is There More than One Way?" in Ibid., p. 41.

[41]Ibid., p. 42.

Fountain House. In 1948, Fountain House was established in New York City to be a social center for former mental patients. This house was conceived by a group of former mental patients from Rockland State Hospital in New York. In 1958, an apartment program was developed in order to meet the residential needs of the members. The purpose of the apartments was to provide a place to live for those who remain in the hospital largely because they have no home to which they can return. It was also formed for those who would find a strained relationship if they returned to their families and those who were living in a lonely, dingy tenement atmosphere. The purpose goes beyond housing, however. There is also the purpose of developing an awareness of neighbors, shop keepers, and coping with household chores. At present, twelve apartments are leased and there are two persons in each apartment. Most residents stay for a few months but some have been there two years. Fountain House provides a 25 per cent subsidy for the residents' care.

To rent an apartment through Fountain House the patient must first be involved in the social program. Here vocational guidance, therapy groups, and social-recreational activities are provided. The members can strengthen primary work habits, attitudes and motivation, as well as build up self esteem and social skills. Over 90 per cent of the apartment members have undergone hospitalization.

Patients, however, whose primary problem is an anti-social personality or epilepsy are not accepted.[42]

Securing an apartment building is not a simple task. First a landlord must be found who is willing to rent to a social agency and accept former mental patients. He must be aware there will be a change of residents about every six months. He must be assured that full responsibility will be assumed by Fountain House for any member placed there. The landlord is assured that he can phone the staff at Fountain House if an emergency arises and that a member will be relocated if it is necessary. Rents are to be paid promptly. Because some landlords have relatives or friends who have had experience with mental illness, apartments have been made available.[43]

Since 1958, sixty members have resided here. At present, nineteen have been re-hospitalized, twenty-two are still in the apartments, three moved with other families, fourteen are on their own, and the whereabouts of two are unknown. Of the twenty-two in the apartments, and the fourteen on their own, eighteen are employed in the community.[44]

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[42]J. Beard, M. Smith, and F. Sorokin, "An Apartment Program for Post-Hospital Psychiatric Patients," in their Conference on the Community Social Club and the Returning Mental Patient (Framingham, Massachusetts: Center House Foundation, November 13, 1963), pp. 87-88, 91.

[43]Ibid., p. 90.

[44]Ibid., p. 95.

Rutland Corner House. In 1877, a temporary residence, employment agency, and rehabilitation center was formed in Boston, Massachusetts for unfortunate women who were homeless or handicapped. The admission criteria were listed as decency, responsibility, and willingness and ability to work. The home was located in a three story building, two blocks from the hospital. There were nine residents plus staff.

In 1954, the charter was amended and now the House is operated solely as a residence for discharged mental patients from the Massachusetts Mental Health Center (Boston Psychopathic Hospital). The role of the director is to be a family surrogate figure, a counselor, confidante, caretaker, supervisor, and cultural teacher.

The patients pay eleven to fifteen dollars per week and the remainder is paid by a wealthy Bostonian. The overall policy is "separate but equal," whereby each resident can live in his own world, yet is entitled to all the privileges. The atmosphere is family orientated. As in many other homes, severe manipulators and sociopaths are excluded.[45]

Out of fifty-five discharged women, forty were interviewed. Of these forty, 69 per cent were living

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[45]David Landy, "Rutland Corner House: A Case Study," Journal of Social Issues XVI (April 1960), 27-29.

satisfactorily in the community. Of 23 per cent that were rehospitalized, seventeen were back in the community.[46]

Measurement of Success of Peer Houses

Wechsler says: "It is as yet too early to evaluate the rehabilitative potential of the half way house."[47] He makes this statement because the program of peer homes is new and adequate records are absent. Most of the records kept by these houses are limited to knowing whether the former residents have returned to the community or have been rehospitalized. The absence of adequate control groups minimizes the significance of such results.[48] Another reason it is difficult to evaluate the rehavilitative potential of the half way peer house is that it is difficult and often unfeasible to have an experimental and control group with people who are still partially ill. Very little is known about the variables along which the patient should be matched and compared. Because of this lack of information, Wechsler feels the commonly used variables of age, sex, and social-economic status are of secondary importance and not crucial.[49]

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[46] Ibid., pp. 29-30.

[47] Wechsler, "Halfway Houses for Former Mental Patients: A Survey," op. cit., p. 26.

[48] Ibid., p. 26.

[49] Landy and Wechsler, op. cit., p. 74.

The length of stay variable Wechsler also questions. He feels that if the control groups are inadequate then neither brevity nor length of stay implies an accomplished objective nor failure of an objective. Even these control groups need a premorbid baseline and criteria.[50] These reasons must make the researcher more cautious in final judgment.

A study was made at Conard House, a residential peer house, in San Francisco. It was found that sixty per cent of their residents moved into the community with sustaining employment, twenty-five per cent with partial self supporting employment, and fifteen per cent returned to the hospital. The staff feels the fact of the former resident sustaining employment is a sign of the value of the residential peer house.[51]

In another study, fifty-five per cent of those placed in family care homes returned within one year. Of those placed in a half way residency, fifteen per cent returned to the hospital within one year. On this basis, the resident peer house was evaluated as providing a successful service to the former patient.[52]

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[50] Ibid., pp. 74-76.

[51] Patricia Gumrukcu, "Is There More Than One Way?" in Glide Urban Foundation, op. cit., p. 39.

[52] Ibid., p. 30.

V. CONCLUSIONS

Half way services originated to help the released mental patient gradually adjust to the more rigorous demands of his new environment. These services provide a partially sheltered environment to meet the appropriate stages of psychological needs and psychological development of the former patient.

Social clubs serve the former mental patient and those persons who are experiencing serious emotional problems. The clubs provide an environment which bridges the gap between isolation and excessive sociability with the community. The clubs offer personal identification and belonging. There are opportunities to share one's emotional problems with others having similar problems. Leisure time activities are also provided.

Vocational services offer employment opportunities to former mental patients. These services provide a place to explore and expand one's employment ability. Some vocational services offer lifetime employment for those who cannot return to regular employment in the community. Others are gradually moved into regular employment. In this way, opportunity is offered for various levels of employable development. This opportunity provides a half way service between the atrophy of work skills in hospitalization and immediate entrance into the community work force.

Day treatment centers allow the released mental patient the opportunity to live in the community while coming to the center for therapy. The person can continue his community life and contacts while receiving the necessary intensive therapy in a controlled environment a few days each week.

Residential houses offer a half way service between hospitalization and immediate return to living in the community. Some former patients do not have a family to whom they can return. Others, having no job and few finances, would have to live in isolation in some dingy room. The residential houses offer a gradual growth in social contacts and personality development.

The various services serve specific problems of the released mental patient and offer environments for a variety of psychological needs and stages of psychological development.

CHAPTER IV

THE ORGANIZATION, PROGRAM, AND PROBLEMS OF TWO HALF WAY SERVICES

In this chapter two half way services will be presented in more detail. The half way services selected are a half way social club and a residential peer house. The social club is Recovery, Incorporated. It is representative of half way services whose main function is rehabilitation through social interaction of persons with similar problems. The residential half way house, Baker Place, is representative of a service that provides social interaction in a living milieu.

I. RECOVERY, INCORPORATED

In 1937, Dr. Abraham Low, a psychiatrist at the University of Illinois Medical School formed a group composed of mental patients and former mental patients. Its purpose was to help prevent relapses and chronicity. Meeting at the hospital the members shared in group therapy under the guidance of a professional moderator. There were Tuesday and Saturday night lecture-discussion groups at the hospital as well as discussion groups that met in homes. A telephone service for emergency counseling was provided.

Social activities completed the program. The lectures and social activities have been discontinued.

In 1941 this group left the hospital's jurisdiction and adopted the name, Recovery, Incorporated. Today Recovery is led by lay people who have experienced mental illness. Former mental patients and others who are emotionally upset are welcome to its meetings. The leaders are trained in Low's method. This method consists of studying his book, "Mental Health Through Will Training," attending the meetings regularly, and practicing the Recovery principles.

Today a meeting usually begins with the leader reading from Low's book or with all members listening to a taped message. A panel of members then makes comments and shares their personal problems with nervousness and emotional crises. Other people present are then invited to ask questions and share some of their problems.[1]

Assumptions in Recovery

Wechsler sees seven basic assumptions in the Recovery program.

1. The returned mental patient and the psychoneurotic both suffer from similar symptoms.
2. The psychoneurotic or post psychotic symptoms are distressing but not dangerous.

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[1]Recovery, Incorporated (Chicago: Recovery, Incorporated, 1958), pp. 3-4, 16-17.

3. Tenseness intensifies and sustains the symptom and should be avoided.
4. Because of excessive irritability, the psychoneurotic and post psychotic are very susceptible to arousal of irritability.
5. Free will is the basis for accepting or rejecting thoughts.
6. Mental health is the supreme goal.
7. The physician is the supreme authority.[2]

By this last statement he means that Recovery neither diagnoses, treats, nor supplants the physician or psychiatrist. Each member is expected to follow the authority of his own professional therapist.

Basic Principles

In the Recovery method, there are basic principles that must be understood and toward which one must strive if he is to find help. These principles are actually used as tools in one's thoughts when he faces a troubling situation.

1. Spotting: the introspective relabeling of the components of the situation for what it is. One must see the situation for what it is rather than fantasying about it.
2. Differentiate between the external and internal environment. The external situation is the reality situation that seldom can be changed while the internal environment is the subjective feelings that can be controlled and reappraised.
3. Avoid a right/wrong judgment. This is considered a subjective judgment and usually leads to a bad temper and excessive fear.

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[2]Henry Wechsler, "The Self Help Organization in the Field: Recovery, Incorporated, Journal of Nervous and Mental Disease CXXX (April 1960), 298.

4. Differentiate between the average and the exceptional. See your symptoms as no worse and yourself no sicker than the average person. You have problems but are not a strange exception.[3]

Basic Functions

Wechsler sees certain basic functions in Low's method. The method provides the emotionally troubled with order in the midst of the anxieties they face. Their anxieties can be reduced by a simple routine and rigid standard procedures. Secondly the method provides controls that strengthen one's defenses against anxiety. The intensity of his anxiety is lessened by learning new ways of dealing with his problems. The power of positive thinking is a third function. It opens the way for self suggestion where all problems are to be seen as manageable. A fourth function helps the member take an active part in the meeting. It also helps to satisfy his needs of dependency. This is accomplished through set routines and rigidity of the procedures. A fifth function provides a cathartic atmosphere where excessive guilt and stigmata can be shared and eliminated. Finally the method is semi-religious. Here faith, acceptance of regulations, self discipline, will power, and Low's book are stressed.[4]

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[3]Ibid., p. 299; Recovery, Incorporated, op. cit., p. 3.

[4]Ibid., pp. 305-307.

Role of Group

The role of the group is to provide a sheltered social environment where no one is stigmatized. At first, if a person is fearful of too much involvement at the Recovery meetings and says so, he is endorsed by the group for expressing his feelings. Later he is endorsed for talking and reading the materials of the program. The group also acts as a controller of behavior where rewards and sanctions are given for raising one's hand to speak as well as sitting and listening to others. Finally, in a wide perspective, one can see himself as a member of one of many country wide Recovery groups.[5]

Role of the Member

While there are specific roles for the group, there are also roles each member is to learn. He must accept the fact that he is different. He is more prone to tenseness; he cannot tolerate certain upsetting situations as well. He must accept the fact that he is similar to the other members. He has emotional problems; they have similar problems. Finally, he must understand that Recovery can strengthen him through repetition of rules and group support. He can find strength even in partial failure if

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[5]Ibid., pp. 308-309.

he knows he will be accepted without judgment. This can help him to exert more effort in his self help.[6]

Role of Leader

The leader is seen as the expert in utilizing the Low method and interpreting it. He is the guardian of the method. He controls the meeting and decides if discussion is in accordance with regulations. He acts the role of the model. He may not be healthier but he is freer from difficulties.[7]

Potential Problems of the Method

In analyzing the Recovery method, Wechsler sees three potential problems.

First he sees the problems arising from membership. The method offers a magical, omnipotent, authoritarian, and unrealistic solution. It does this by putting the lid on feelings. It suppresses them, rather than bringing them to consciousness. The method is, therefore, superficial, limited, and prevents insight. It is regressive in that it fixes defenses and forces adjustment at a low level of maturity. It creates complacency about the problem of mental illness. Instead of helping the member work through the problem, one instead controls it.[8]

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[6]Ibid., p. 304. [7]Ibid., p. 305. [8]Ibid., p. 309.

Secondly, there are problems related to the absence of a professional. Too many members have had little if any professional treatment. The leaders themselves may be ill and manipulative. The leaders are selected simply by passing a course and obtaining approval from a Board of Directors. Some members may leave too soon or stay too long for there is no graduation policy at present. Again there is no professional who can modify and correct statements and make final summaries. There are no formal connections with aftercare services. Because control of deviancy is lacking, bizarre and deviant behavior can be fostered by a fringe group within the club.[9]

Finally, Wechsler sees problems related to the method. It is a rigid method for it is literally applied to all examples presented. It is seen as a perfected, finished system of self help. Because the stress is upon control, adequate mechanisms to release affect may be neglected. The method is superficial for it does not probe for the etiology of the symptom. It is also regressive and infantile for one must give complete obedience to authority. The emphasis on inspiration may not allow for a realistic appraisal of the severity of the illness. Outsiders may judge all of the groups behavior from the behavior of one member who is overly nervous.[10]

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[9] Ibid., pp. 310-311. [10] Ibid., pp. 311-314.

A personal reaction to these criticisms is to acknowledge their constructiveness. Wechsler is correct in his warning about applying one method to all problems presented. This overlooks the uniqueness of persons and the fact that there are other helpful, though different, approaches to the problem of mental illness. The danger of non-professional leadership is also appropo. The leaders may manipulate the group to their own advantage. Though this can also be true of the professionals, the danger is lessened.

Conclusion

Granted these warnings must be taken into consideration, the Recovery program has provided courage and comfort to many people. Some persons thrive on the rigidity of the method and find their needs of dependency satisfied. Again, it is not the method so much as those handling the method. The method stresses the need of professional help outside the club. The suggestion can also be made to professional therapists to visit the club and refer some of their clients to it.

If Recovery, Incorporated, is willing to take an honest look at these criticisms and make changes where feasible, the organization will continue to be a great asset to those who have left the hospital and to those struggling with emotional problems.

II. BAKER PLACE

A city can be a very cold and impersonal place, especially to a newcomer who has made no friends. Even after some time of residency, many are still alone. The greater tolerance and liberality of the city has its counterpart in tremendous depersonalization and interpersonal ethical and emotional control. The outcome is often destructive. San Francisco is no exception. In fact it could be seen as a magnification of most other cities.

In this city, the Glide Urban Foundation was formed to explore ways in which the church could become involved with young adults in the city. One direction that had possibilities was the formation of a half way house to serve recently discharged mental patients or those under environmental stress who could profit by such a residential experience.

Continuing their research, the staff at Glide Foundation discovered many persons leaving the hospitals who could neither return to their family constellation nor go directly into the community to rely solely on their still weak personal resources. The family care homes were insufficient in number. In the San Francisco area, there had been only fifty such homes while one-hundred people were

leaving the Northern California hospitals each month.[11] Working closely with Patricia Gumrukcu, a sociologist and then staff consultant at Conard House, an already existing half way psychiatric residence, the Glide staff decided another house was needed.

Organization of Baker Place. In conversation with Rev. Lewis Durham, director of the Glide Foundation, it was learned that in the Spring of 1964, the staff at Glide planned a retreat with four nearby Methodist churches. The theme of the retreat was the mission of the church. The prospective half way house was mentioned as a possible mission. After the retreat one of the laymen became so enthused he recruited other members of his church, Park Presidio, to volunteer for training.

The Glide Foundation sponsored a sixteen week training program. It was led by a psychiatrist, Dr. Price Cobbs, Patricia Gumrukcu, and the resident director and founder of Conard House, Elaine Mikels.

The content of the training program involved a history of mental illness and a history of half way houses. It dealt with the problems that led to the patients' hospitalization. One session told what life was like in a

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[11]Patricia Gumrukcu, "Mostly in the Last Ten Years," in Glide Urban Foundation, Specialized Housing for Young Adults (San Francisco: 1964), p. 15.

hospital. It concluded with a look at various treatment facilities and inter-personal problems caused by the social structures.

In June, 1964, this training program led most of the volunteer trainees to agree to sponsor a half way house for the mentally troubled. A large residence on Baker Street in San Francisco was purchased by the San Francisco United Methodist Mission and it was placed under the sponsorship of the Park Presidio Methodist Church. The members who had taken the training then prepared the house for occupancy. They gathered furniture, painted, laid rugs, did repair work, and obtained the permits necessary for occupancy.

At the same time, Dr. Cobbs and Mrs. Gumrukcu, were setting up screening-interview schedules for resident-patients and arranging for resident managers who would live in the house.[12] In conversation with Patricia Gumrukcu in San Francisco on April 7, 1966 it was learned that the experiences learned at Conard House provided the basic patterns for Baker Place.

Problems in obtaining a house. Before the actual purchase of the house, it was important to find an interracial neighborhood, since the residence was to be integrated. The home needed to be near a transportation

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[12]Glide Urban Foundation, in Ibid., p. i.

system. Grocery and laundry facilities had to be within walking distance. The size of the house was determined by the number of people who would reside there. Baker Place estimated between 20-25 residents. An older home was chosen because it provided a feeling of spaciousness and a lived in quality of homeyness. As meals were to be served, the kitchen facilities had to be spacious and adequate.[13]

In regard to informing the community about the project, two possibilities were considered. First they considered sending a staff member into the neighborhood to solicit support. He would tell the community about the plans for a house and then hope for sympathy and cooperation. The problem that was envisioned with this method was that the neighborhood might reject and defeat the attempt. The second possibility was to purchase a house, move the young adults in slowly, and see what would happen.

It was decided that Baker Place would follow the second method. A house was purchased by the Methodist Mission without solicitation. As soon as the house was renovated in late 1964, selected persons were granted residency. There are now sixteen young adults in residence, and the projected goal is twenty to twenty-five.

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[13]Elaine Mikels, "So You Would Like To Start a Halfway House," in Ibid., pp. 20-21.

The church members learned that city and state regulations had to be studied before a home was purchased. In San Francisco, the urban code was strict. A rooming house had to have a hotel license. The requirements for this license were obtainable at the Public Health Department. The house had to have adequate fire escapes, automatic sprinklers, specific ceiling heights, and forms of egress from the bedrooms. There were also limits on the number of persons that could sleep in one room. Because the building would be coed, separate bathrooms were needed on each floor.[14]

Lay and professional relations. One of the problems which presented itself was: "should lay personnel or professionals be in charge of Baker Place?" In the United States, three fourths of the residential houses are non-professionally managed.[15] Some feel the non-professionals will tend to rely too much on the professionals if a professional is in charge. The home will become merely a place to live rather than a socially therapeutic group. Other opponents of a non-professional staff state that the non-professionals may be unaware of their own feelings.

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[14]Mikels, Ibid., pp. 20-21.

[15]Gumrukcu, op. cit., p. 16.

The proponents for lay leadership feel a non-professional who lives in the house is more effective than a professional. They feel a professional usually lives outside the home and is therefore removed from the living situation. The professional, therefore, often has only a paternal and distant relationship to the residents. At Baker Place such a strained relationship between professional and non-professional staff does not exist. The entire staff works in close cooperation with one another.

The present directors of the house are two young adults, male and female biology majors, who are upper classmen at nearby colleges. They were selected for a one year internship. They were chosen for their personality and ability to handle their own problems.

The role of these house managers is to initiate and administer the program. They meet weekly with Price Cobbs or Patricia Gumrukcu to discuss any problems that may have occurred. They collect rents and act as adult guarantors.

> An adult guarantor is one who stands as a participating symbol, guaranteeing that the resident will find his efforts worth the price of investing himself. The residents can share in dialogue with him under the assurance that he will understand and see the problem the resident faces with genuine concern.[16]

These resident managers represent for the patients, young

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[16]Glide Urban Foundation, op. cit., p.v.

adults who have been able to successfully live in society. The resident managers serve as peer and parent figures.

The volunteers from the sponsoring church contribute to the therapeutic climate and process by listening and sharing. It is hoped that each volunteer will grow in an awareness of his own problems and limitations. Each is to avoid becoming involved as a contender in the interaction of the residents. Each is to be natural and non-patronizing to avoid an over dependent relationship.

At Baker Place, the volunteers are to allow the resident-patients both seclusion and closeness. Confidences are to be respected unless the thoughts, feelings, or actions are detrimental or destructive to others or oneself. If the resident directors or volunteers feel a possible crisis is arising, they can call the psychiatrist at any time.[17]

The volunteers meet once a month with Patricia Gumrukcu and Lewis Durham. At this meeting they discuss finances, the program at the house, problems that have been raised as to selection of resident-patients and the behavior of resident-patients.

The attitude of the professional staff at Baker Place can be summarized in this statement. "We have no set

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[17]Gumrukcu, op. cit., p. 17.

idea what profession is best attuned to the half way house and no investigation of the best type of training..we see the total house as an agent for change."[18]

Selection of resident-patients. Baker Place had to set some standards of eligibility for the selection of these resident-patients. They decided that teen agers would require more supervision and individual help. The house would then have to be limited to a maximum of eighteen residents. They felt anyone over forty-five years of age would require more custodial care and have different needs than younger residents. As the interest was to serve the young adult, they agreed to serve both male and female who were unattached and between the age of eighteen and forty five. Baker Place accepted patients released from mental hospitals, applicants who experienced an emotional crisis, and those who were marginally retarded. There were no racial, ethnic or religious limitations. As less supervision would be needed, the emphasis could be on living milieu and contacts. For economy, no less than twelve would be received into residency. For rapport and intimacy, no more than thirty would be accepted.

On the information-application brochure the cost for a semi-private room is listed as between forty and

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[18] Ibid., p. 17.

fifty dollars plus a ten dollar service charge per month. Each resident must be willing to buy his own food, care for himself, and cook on a cooperative, community basis. Each resident must have financial resources of at least $125 per month and intend to reside in the metropolitan area.

The professional staff is responsible for screening the applicants. They seek out those who are motivated to develop stability in self care, such as employment. They also seek those who seem able to handle their behavior appropriately in the group setting of Baker Place.

The program. The program at Baker Place is as spontaneous and unstructured as possible. Gumrukcu calls it a program with two syndromes. The first syndrome is the "anti-free ticket" syndrome. The staff does not attempt to get free tickets in order to take the residents to sport events and theater shows. While the staff acts as catalysts in urging the residents to involve themselves in community outings, the staff wants the residents to make the plans and decisions. The idea of the staff taking the resident is therefore avoided.

The second syndrome is the "stairway" syndrome. In place of many planned meetings and appointments, the staff is to respond to the resident's needs as the resident presents them. If the resident confronts a staff member on

the stairway or in the kitchen, the staff member should feel free to become involved. This concept recognizes the therapeutic value of a spontaneous encounter.

Once a week the resident-directors meet with the resident-patients. The resident directors lead the group in discussion of any house problems that may have occurred and any plans that need to be shared. At this time informal parties, movie dates and other get togethers are discussed. The professional staff is available about once each week for any vocational and psychological counseling that may be needed.

Disciplines and expectations.

> In a recent study under the aegis of the United Community Fund around the subject of young adult housing, it was discovered in talking with managers of guest and boarding houses, that approximately 90% do not have any house government or residential participation.[19]

The staff at Baker Place feels that if rules are too strict, the residents will flagrantly violate them. If no rules are presented, the residents can become confused and disturbed. The residents need correct models with whom they can identify. The persons acting as models can show the residents the need to conform to socially acceptable patterns of behavior. They can stimulate corrective emotional experiences for the residents. The staff at Baker

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[19] Ibid., p. iii.

Place believes in the philosophy of one director who is quoted as saying:

> Our house rules are all the rules of common sense, safety, courtesy and morality by conventional middle class standards and if you need to find out what they are, all you need to do is break one.[20]

At Baker Place, there is a positive permissiveness. As needs arise, the residents and staff set up new rules or modify the old ones. Most of the rules apply to problems that would affect other residents. Decisions involving individual problems are left to the person so he may experience adult behavior. For example, rent is to be paid on time and there are a set number of times each resident is to clean his room. Each resident is expected to be present in resident government planning in order to exercise responsibility. However, he is free to refuse to participate in informal discussions.

The information brochure of Baker Place states that each resident is expected to move into the larger community within nine months. The staff places great emphasis upon employment of the resident. After one month of residency, each resident is expected to have or be in search of employment.

The staff at Baker Place does not see discipline as a set of rules. They do not see discipline as coercion.

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[20] Ibid., p. 18.

Instead the staff plans their program to help the residents internalize discipline as basic to the residents' growth. The staff acts as models with whom the residents can identify.

Measurement of success. Gumrukcu has divided the resident-patients with whom she has worked into five categories. The categories show degrees of success or failure of residents in a psychiatric half way house.

> Way stationer: this is the easiest person to serve. They stay about one month. Though they do not desparately need the facility, without it they may have trouble getting employment and established in the community. Alone, at first, they respond quickly and are cooperative.
> Saturated graduate: this person stays the entire year and shows the most beneficial change. They have a great need for attention and support.
> Poor referrals: they stay less than one month and return to the hospital with the post-hospital bends. Unually they came out of the hospital too soon and had no screening for the half way house.
> Premature departee: this is the person too well for the hospital, too sick for the community. They often have trouble mobilizing in the half way house and soon leave. They do return for social activities.
> Plateau rider: they are the chronics who stay as long as they can but don't seem to succeed. They cannot hold a job and make others feel their uncomfort.[21]

In the primary screening interview, some idea of the applicant's success can be determined by his motivation. Those who were highly motivated before coming into the half way

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[21] Ibid., pp. 28-30.

house generally tended to succeed even though their previous employment record was poor.[22]

After becoming a resident one sign of progress is the movement of the individual from the cocoon of self into the world of the group. Clues that show progress in the group involvement of Baker Place residents can be summarized as follows:

1. More prompt and constant attendance by members.
2. The development of some formal organization and a willingness to take responsibility for the work of the group.
3. The members discuss the group as "we" and "us" in conversation.
4. A decline in anxiety.
5. A wider range of participation and a more enthusiastic response. There is often a pattern of dominance in seating arrangements around the table.[23]

Another sign of progress at Baker Place is the increasing interest the resident places in his personal self care. This shows a growing ego strength. Finally, a resident is considered progressing when he seeks employment and is able to sustain involvement in it. In conversation with Patricia Gumrukcu, it was learned that she is presently working on a project to determine how successful the resident-patients are in their employment one year after leaving Baker Place.

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[22] Ibid., pp. 27-28.

[23] Harleigh B. Trecker, Social Group Work (New York: Woman's Press, 1948), pp. 71-72.

Conclusion. The staff at Baker Place has stressed the use of non-professionals in working with the resident-patients. Baker Place uses residential managers who are seminary or college students. The professional staff is available when need for vocational, psychological and medical service arises. The program is spontaneous and unstructured. The emphasis is therefore upon what the patient can do for himself.

The staff at Baker Place and the sponsoring church, Park Presidio Methodist, have shown that a church fellowship can take a personal and active part in the area of mental illness and mental health. They have become a model for other churches that might consider such a service in this area.

CHAPTER V

SOME ISSUES INVOLVED IN A RELATIONSHIP BETWEEN THE MENTALLY ILL AND THE CHURCH MEMBER

In Chapter VI some practical ways of relating the church to the half way movement will be presented. Before this is done, it is necessary to understand some of the issues that can arise between those who have faced mental illness and the members of a church interested in half way services. Before a church fellowship considers undertaking a half way service, the fellowship should understand the feelings of the patient. The fellowship should also understand their own feelings towards mental illness and their motivation for mission in this area.

The first section will present some issues raised by presently hospitalized patients as well as former patients. The second section will present some difficulties that can arise among members of a church where half way services to the mentally ill are being considered.

I. THE CRY FOR HELP: THE PATIENT

Separation from the Community (hospitalization)

When a person is unable to find alternatives or adjust to the demands made upon him by his society, he can withdraw from others into self isolation. As his mental

process becomes less controllable and less rational, the person must be hospitalized. Once hospitalized, the person faces more isolation. He now feels the stigma of failure that is associated with mental illness.

The patient feels ashamed. He feels ashamed because he has failed himself, his family, and his community. His confused self image becomes more distorted. Fearful that he may be recognized for what he feels himself to be, totally depraved, he tries to become more secretive and isolated from others.

The patient feels anxious. Ernest Bruder, supervising Chaplain at St. Elizabeth's Hospital in Washington, D.C., expresses the anxiety felt by the mental patient when he says:

> It is when the hidden or 'shut up ness' can no longer remain so, and threatens to be revealed, that we can say the individual has been possessed by the illness which is in itself an attempt to deny the knowledge of the hidden. It is the very powerlessness to control or avoid the thoughts, impulses and wishes which seem to overwhelm him that arouses such frank terror in the disturbed individual.[1]

For example, the patient may cry out that he is God in order not to admit that he is puny and scared.

In the hospital, he must adapt to a different world. This is a lonely and unfamiliar one. Even here he is

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[1]Ernest Bruder, Ministering to Deeply Troubled People. (Englewood Cliffs: Prentice Hall, 1963), p. 32.

bruised by unexpected reminders: the family never has time to visit; the letter that says the spouse is filing for divorce; the ever constant question of where the patient will go and how he will be accepted when he is released. In the hospital, anxiety is not erased. The community within the hospital creates its own anxieties. It is a community of sick people. In this climate deviancy is accepted. Only a fine line divides tolerance from habituation. Many patients at Patton State Hospital stated they longed for healthy relationships. They wanted to prevent a growing habituation toward hospitalization as the accepted way of life. Some patients refused to talk with other patients because most conversations centered only on one's illness. Most patients suffered the anxiety of becoming habituated to the sickness role, and the anxiety of returning to the community.

The patient feels guilty. He has been hurt deeply. He begins to blame himself for everything that happens. The fact that he has been ostracized changes into a feeling that he should be ostracized. He accepts his punishment but neither feels forgiveness nor fully understands why.

Despite all these burdens, most patients struggle to get well. Most care. Most want to get out. Like a fever, the illness is itself an attempt to cure some overwhelming tension with which he could not cope. He is

constantly struggling with integrity. What he denies in words he may affirm in practice or vice versa. Bruder acknowledges that patients are not willing to accept their illness as a final defeat. They constantly struggle against giving up those parts of themselves with which they must come to terms.[2]

Anyone who plans to become involved in half way services for former mental patients, needs to be aware of the feelings and struggles the patient has experienced during his hospitalization. Though the former patient leaves the hospital with a somewhat improved self image, he will still feel some stigma of failure. The half way worker must be aware of this in order to relate to the person.

Return to the World

Leaving the hospital is similar to entering. The problems are not alleviated but are magnified. The security of the hospital is left behind. The patient must adjust to a different way of life, a way of life that originally placed him in the hospital.

Social readjustment. Most patients must find meaningful relationships with others. Otherwise, they may soon

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[2]Ibid., p. 28.

be rehospitalized. For some who have failed to organize their personalities from early in life, there must be a new learning about normal human relations. Others must be motivated to relate to the world. They must first determine that the world is pleasant and worth the effort to relate.[3]

Legal problems. Besides the emotional-psychological problems, the released patient must face legal complications. Upon commitment to the hospital, his driver's license is suspended. After release, it often takes weeks to be renewed. This is one of the bitterest complaints registered at the Patton State Hospital. After a person leaves the hospital he may be invited to resume his previous employment. Unable to provide his own means of transportation, however, he cannot accept the offer. Salesmen, especially, are bitter about this situation.

Employment problems. Another problem the patient faces upon release is in regard to employment. Should the released patient tell his employer he has been hospitalized for mental illness if the employer does not know? For some this raises little problem; for others it means being refused employment. A struggle with integrity often ensues.

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[3]Bruno Bettelheim, Love Is Not Enough (Glencoe, Ill.: Free Press, 1950), p. 27.

If the patient is honest he may lose his job. If he is dishonest, he fears disclosure.

To better understand some of the employment problems faced by former mental patients, a study was made in the Boston area. In this study, it was found that about 70 per cent of the hospitalized workers in the greater Boston labor market were reemployed after discharge. However, more than two-thirds of the employers had no knowledge their workers had been hospitalized.[4] The study also suggests that "employers tend to have a more accepting attitude toward their own employees with a history of mental illness than toward the job applicant with a similar history."[5]

In this same study, two hundred employers were contacted. Of those responding 153 or about 75 per cent said they would rehire ex-mental patients. However, only twenty-seven employers or 13 per cent did knowingly hire any former patient during a three year period. Of the jobs available, 30 per cent of the employers said they would place the ex-patient in any job for which they were qualified. Forty per cent of the employers would place them in

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[4]Simon Olshansky, Samuel Grob and Irene Malamud, "Employer's Attitudes and Practices in the Hiring of Ex-Mental Patients," Mental Hygiene XLII (July 1958), 393.

[5]Ibid., p. 393.

selective jobs. These jobs are often low paying and insignificant. Employers place them in these jobs partially because of fear, because the patient asks for such a job, and because of low self esteem. Before hiring, most employers require a personal interview and a doctor's recommendation.[6]

The most significant fact emerging from this study is the limited experience the employer has with former mental patients. Though in conversation he may agree they should be hired, in practice he is overly cautious.[7] His feelings can be summed up in the statement: "We don't hire what we can't understand or feel reasonably sure we can predict."[8]

Case Studies

A patient who had been a prostitute until she suffered a breakdown that was diagnosed as schizophrenia told why she constantly cried in the hospital. After explaining that it was not grief over her past she said:

> The tears were the outcome of the terrifying frustration of having lost the power to think clearly, of fighting as hopelessly as a blind man chasing shadows to catch logic and perspective...I had lost the power

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[6] Ibid., pp. 394-396. [7] Ibid., pp. 397-400.

[8] Joan F. Murray, "An Experiment in Changing the Attitudes of Employers toward Mental Illness," Mental Hygiene XLII (July 1958), 406.

> to think. I was sure I was doomed to stay in this land of shadows forever...Solutions were offered but I became scared of them...feeling that in my confusion one of them might lead me along some path I should not take. I was no longer master of my future, but I could not face the idea of someone else's directing it while I was in no condition to stop or regulate them.[9]

In another case, a mental hospital patient gave these suggestions to the hospital chaplain who had asked her two questions: "What makes it hard for you to become a person?"; "What still troubles you as you think of joining the human race?" The patient answered:

> Fortunate is the child who, amidst the many do's and don'ts and rules and regulations...retains the feeling of being loved for himself by someone. Love is a priceless thing, and easily misused as a reward for obedience and good behavior. If you do not obey ...God will not love you and mother will not love you either...Deep inside I did not feel loved or wanted... the old feelings of despair, futility, and inability to go on.[10]

As the conversation continued, she told how she felt soon after her hospital admittance.

> Enough interest was taken in me to make me really try for awhile. But I couldn't keep up my own end of it and fast lost support. 'You must help yourself,' they said, but there was no help in me. After some two years of therapy, I saw that my therapist could not save me either and damned beyond redemption, all belief in myself gone, I finally lost contact... Months later I awoke. I knew it could be nothing I had done...No one could have done this but God! But that would mean that I had been forgiven things that couldn't be forgiven...I was more important than my

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[9] Streetwalker (New York: Viking Press, 1960), p. 174.

[10] Bruder, op. cit., pp. 60-61.

> sins. When you know that God is for you, no matter how discouraging the situation-you are lifted above it.[11]

In a final case a letter was written by a former patient to the columnist, Abigail Van Buren who had visited her in the hospital and later wrote to her.

> You made me feel that you really cared about what happened to me. That's why I'm writing to tell you I've been medically discharged. There were some rough times, Abby...but I never 'let go' because I knew that ...people like you were pulling for me. It may sound corny, but when a person is in a situation like I was in, it's important to know that people care. There are still many prejudices against those who have been hospitalized for a mental or emotional illness. I want people who have only heard of mental illness to know that we are like everyone else; we aren't possessed of evil spirits. We are 'ill,' just as if we had a broken leg or appendicitis. And most important of all, we can be cured.[12]

Conclusion

The cry of the mental patient and the former mental patient is a cry for help. With many personal relationships strained or broken they are seeking to find someone who will relate to them and they are crying out to somehow relate to the world. These are the social problems they face. There are also problems with law and employment. In all of their suffering, they struggle toward facing the trouble that earlier overwhelmed them.

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[11] Ibid., pp. 62-63.

[12] Abigail Van Buren, "Dear Abby," Los Angeles Times, (October 4, 1965), p. 5.

The church fellowship that would meet the needs of the former mental patient can best serve by understanding the struggles this person has faced and continues to face.

II. THE PROBLEM OF ATTITUDES IN CHURCH INVOLVEMENT

The cry for help of those who are emotionally troubled is constant. The fellowship of the church needs to hear the call and respond with half way services. Many church members appear not to hear the call or they avoid it. There is often resistance to involvement with the former mental patient. Why? Boisen succinctly states this problem when he says that mental disorders are essentially spiritual and therefore in the realm of service by the church.

> But of any such possibilities the Church is utterly oblivious. She takes no interest in cases of pronounced mental disorder...We have therefore this truly remarkable situation. A Church which has always been interested in the care of the sick, confining her efforts to the types of cases (physical illness) in which religion has least concern and least to contribute, while in those types in which it is impossible to tell where the domain of the medical worker leaves off and that of the religious worker begins, there the Church is doing nothing.[13]

In this section some of the barriers of attitude that hinder the church member from being more involved in answering this cry for help will be presented. These attitudes were expressed in the Fall of 1965, by members of the First Christian Church, Fullerton, California.

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[13]Anton T. Boisen, "The Challenge to Our Seminaries," Christian Work (January 1926), p. 8.

The strong and the weak. Prevalent among church members, as in all of society, is a presupposition that anyone who has been mentally ill is weak. This assumption is further complicated by the inference that a weakness can be dangerous to the strength of society. Nietzsche emphasized this when he said:

> The sick are the greatest danger for the well. The weaker, not the stronger are the strong's undoing... The morbid are our greatest peril-not the 'bad' men, not the predatory beings... are undermining the vitality of the race, poisoning our trust in life, and putting humanity in question.[14]

This attitude can hinder any half way involvement. An inner resistance occurs toward accepting these former mental patients. It is felt these "weaker" people might destroy some of the strength of the "social community" that has evolved around the church members.

Tournier, a Swiss psychiatrist, reminds the church that human beings are quite alike. He says those who want to relate to the ill must realize that all people have weaknesses as well as strengths. Genuine weakness needs to be developed in all people. Genuine weakness is the confession that all men have limitations. It is acknowledging that a person needs the assistance of others. It is knowing a person is accepted in the midst of his weakness. Out of this confession comes genuine strength. In this honesty

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[14]F. Nietzsche; in William James, The Varieties of Religious Experience (New York: Longman's, Green, 1928), pp. 372-373.

of confession the mask of pretence is removed.[15] Any church member, who wants to gain support from the church board for a half way service, must be aware of these strong and weak presuppositions held by many in the fellowship. As preparation for half way service, greater personal honesty must be developed among the fellowship.

Fear of the strange. Experience seems to bear out the fact that what we do not understand we fear. If there is an excessive fear toward mental illness in the church, motivation for half way services will be limited. The behavior of most people is acceptable unless it becomes unpredictable, impulsive, in which there is a loss of control, or extremely irrational. The average person believes rationality and the ability to exercise self control are the central and basic human qualities. When the person's rationality seems impaired and his actions become uncontrolled the basic human traits of the person appear to be lost. This is usually defined as mental illness.[16]

One reason for fearing this irrationality and lack of control is a justified desire for self preservation.

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[15]Paul Tournier, The Strong and the Weak (Philadelphia: Westminster Press, 1963), p. 18.

[16]Charlotte Schwartz, "The Nature of Community Attitude Toward Mental Illness," Conference on the Community Social Club and the Returning Mental Patient. Framingham, Mass.: Center House Foundation (November 13, 1963), pp. 41, 43-44.

Most people do not want to be hurt or destroyed. A stable society depends upon people acting according to the rules of right conduct in that society and upon believing that others will do so.

However, this fear often becomes a vague anxiety even after the ill person has been mentally restored. One reason for this anxiety being aroused within the members of society is the feeling that they too may be influenced and overwhelmed by irrationality. The defenses that secure one's personal problems are threatened. In order to avoid anything that may activate one's personal problems the members of society withdraw from personal involvement.[17] A resolution of this anxiety is to send the person away. The reason is given that here the ill person can receive better treatment. This is true in part. The hospital is better equipped to help the person. The danger is that once the person is hospitalized, the church or society too often assumes it has no more responsibility.

There is another reason people become anxious in the presence of mental illness. Mental illness is seen only as chaos, destruction, as disintegration of the self. This is threatening to mankind. Man seeks the security of order.

Boisen challenges the feeling that mental illness is only destructive. He sees in mental illness a struggle

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[17] Ibid., p. 46-47.

and emotional upheaval moving toward healing and reorganization. To him this is similar to a religious transformation. The difference lies in the outcome. If successful it is called a religious experience; if unsuccessful it is called insanity.[18]

Mental illness is a matter of degree rather than of kind. It is represented on a continuum from wholeness through degrees of illness to extreme sickness: wholeness, personality disorders, minor neurosis, severe neurosis, and then denial and evasion of reality. Here mental illness begins. Now, the rational thought processes are affected, as well as the emotional and judgmental factors. In an area which may be painful to the patient, such as family life, the patient may become delusional.

However, there are less painful areas, such as conversing about the latest news events, where a mentally ill person may adequately function. Rather than inseparable gulfs, then, between the mentally healthy and ill, there are areas where patient and church member can relate. In these areas, the church member can provide a relationship in which the patient can gain courage in his struggle to obtain healing and reorganization of his life.

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[18]Anton Boisen, The Exploration of the Inner World (New York: Harper and Brothers, 1936), p. ix.

False pietism. A widely accepted assumption prevalent among some church fellowships is the assumption that God only moves through the church to the world.[19] Under this assumption, God is seen as always initiating change from inside the church and then out into the world. God initiates change from inside the believer and then out into life. This often leads to a self righteousness among church members. The church becomes a refuge instead of a headquarters for mission.[20] This is a pietistic position and is a perversion of Biblical Christianity, says Colin Williams, a Methodist theologian. Williams says:

> God spoke to Israel through his action in outside events,-so through the actions of a Cyrus and in the events of an exile, he called them to obedience. Christ called upon his followers to learn to read the signs of the times; and warned them that not only must they be ready to hear his call from the needs of the world-from the sick, the imprisoned, the hungry, the naked-but also they must confess that often 'outsiders' respond to his call before believers (Matt. 25:31-46).[21]

This means that God is not only working in the world but is calling to the church fellowship from the world. This means the church fellowship must be learning to take shape around the world's needs. The cry for help of the mentally ill and mentally restored for a fellowship that is concerned for them has been emphasized in previous sections.

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[19]Colin Williams, What in the World? (New York: National Council of the Churches of Christ in U.S.A., 1964), pp. 44-45.

[20]Ibid., p. 45.

[21]Ibid., p. 45.

If the church membership concurs with the perspective taken by Williams, the beginning of a theological foundation for half way services is provided. God has called to the fellowship. In their response, to form a social club, sheltered workshop, or residential house, the fellowship is shaping their mission of half way service around their communities needs.

Conclusion

In this section, some reasons held by many church members for not becoming involved in half way services have been presented. These reasons are influenced by a person's attitudes and deeper feelings. Many of these attitudes are due to a threatening anxiety about one's own inadequacies as a person. Other attitudes are due mainly to a misinterpretation of our Biblical heritage.

This section concludes by stressing the need for the church members to be aware of their personal attitudes and fears. The church fellowship is challenged to correct the pietistic perversion that sees God only working through the church to the world. The call of God must also be seen as coming from the world to the church. To respond, the fellowship must shape their mission around the needs of the world.

CHAPTER VI

THE ROLE OF THE CHURCH IN THE HALF WAY MOVEMENT

In Chapter V many of the problems that were encountered in a relationship between the former mental patient and some members of First Christian Church, Fullerton, California, were stated. The answer to the cries of need is not denial of those needs. The answer is involvement. In this chapter the ways in which church members can be personally involved in half way services will be considered.

I. THE ATTITUDES FOR MISSION

If the members of a church intend to involve themselves in half way services to former mental patients, they must first be aware of their motivation for mission. The effectiveness of their relationship to the former mental patient will be greatly determined by their attitudes toward mental illness and toward a person who has been hospitalized with this mental illness. Their effectiveness will be affected by their personal self worth and acceptance of self. The Rev. Jesse Moore, Supervising Chaplain at Patton State Hospital encouraged his chaplain interns during the summer of 1965, to experience seven attitudes in their relationship with the mentally ill. He feels as one experiences these attitudes in his life, he will be more

effective in his mission to serve the former mental patient. The seven attitudes, as provided by Chaplain Moore, are presented in this section of the paper.

1. The attitude of accepting the other person as a person and child of God. A member of the First Christian Church in Fullerton, California expressed the feeling of some of his fellow church members when he said that persons afflicted with mental illness are seen as aliens to man and God. The bizarre actions, confused speech, and outbursts of irrationality of the mentally ill often create an excessive fear in the onlooker. The patient is stigmatized as a stranger to be avoided. The patient is often considered less than human. This stigma usually continues after the mental patient is released from the hospital. The church member will not be able to form an effective relationship until he can begin to accept the former patient as a human being created by God. The former patient must be seen as similar to the church member. The former patient loves and hates, feels pain and joy, feels loneliness and wants to feel acceptance. The former patient is a child of God who has value and is worth saving. If the church member can see the former patient as a member of God's creation, it means the relationship between the church member and the former patient becomes one of brotherhood rather than one of alienation. A mental patient, in conversation with Ernest Bruder, expressed this attitude when she said:

> A group of people who care about me more than my behavior-who hear me and see me for what I am, and understand-who accept me for myself on a level with themselves. It has taken me a long time to believe it, because it has taken me a long time to accept myself, let alone find myself in the first place for I was hopelessly buried under years of denial...Many times I would have given up, but they would not let me. They believed in me. And though I did not believe in myself, I believed in one of them, so I kept trying... And now I see something I did not see before-that I am needed by other people for myself as much as I needed this for my own sake...It is not just my problem-it is one that we all share in common.[1]

The patient is alone and feels unacceptable. The patient seeks an order amid this chaos. In a relationship with someone who can accept him as a person, the patient can grasp some order. Out of a former brokenness in relationships, a renewing relationship can begin. These words of Teilhard de Chardin, a French palaeontologist and Jesuit priest, seem to express this event when he says:

> The outcome of the world, the gates of the future... these are not thrown open to a few of the priviledged nor to one chosen people to the exclusion of all others. They will open to an advance of all together, in a direction in which all together can join and find completion in a spiritual rennovation of the earth.[2]

2. <u>The attitude of concern for the needs of the other person equivalent to one's own needs</u>. A church member involved in a half way service must recognize that in

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[1]Ernest E. Bruder, <u>Ministering to Deeply Troubled People</u> (Englewood Cliffs: Prentice Hall, 1963), p. 63.

[2]Pierre Teilhard de Chardin, <u>The Phenomenon of Man</u> (New York: Harper & Row, 1959), p. 244.

attempting to provide fulfillment for the needs of the former hospital patient, the worker is finding satisfaction for his own needs. Like the former patient, the worker has a need to be accepted and feel a sense of worth. When this attitude of need is recognized by the worker, the relationship becomes one of mutual sharing. There is giving and receiving by the participants.

The church member can now see his role as providing suggestions, tools, and alternatives for the former patient. The church workers' role can now be seen as working in co-operation with the former patient, rather than doing things for the former patient. In this way, the church worker allows the ex-patient the freedom to make his own personal decision. When the worker acknowledges the former patient's freedom to decide, whatever choice the former patient makes can now be seen as growth of the ex-patient, rather than a personal rejection of the worker.

3. <u>The attitude of perceiving and understanding the feelings of the other person as they occur and one's communication and appreciation of them</u>. Those who intend to involve themselves in a half way service for former mental patients need to develop the attitude of perceiving and understanding the feelings of these patients.

In order to do this, the half way worker must learn to be patient in listening, and slow to provide advice.

The worker must look beneath the symptoms to the depth of feeling the patient is sharing. This perception and understanding must then be appreciatively communicated to the patient by the worker. The patient must know the worker perceives correctly. The patient must know the worker appreciates the patient's honesty and courage in sharing these feelings.

This conversation is therefore not a monologue of observing the other. Instead, both worker and patient are called to a dialogue of relationship. Martin Buber, a Jewish scholar and lay theologian speaks of this relationship when he says: "the object says something to me that enters my life. I have got to do with him-a word demanding an answer has happened to me."[3]

4. The attitude of letting the other person express whatever feelings he wants to express. Like other people, the former mental patient needs to know someone can accept even his most fearful feelings. He needs to know there is someone who will listen to whatever he needs to express. Anton Boisen feels one of the fundamental evils in mental illness is the fearful inability of a person to tell another person his deeper secrets. In its place is worn a

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[3]Martin Buber, Between Man and Man (London: Routledge and Kegan Paul, 1947), p. 9.

mask of disguise and deceit. The person, therefore, lives in isolation and estrangement from his fellow man.[4] Dietrich Bonhoeffer, a German pastor who died in a Nazi prison camp during World War II, also expressed this fear of confession and resultant isolation.

> Sin demands to have a man by himself. It withdraws him from the community. The more isolated a person is, the more destructive will be the power of sin over him, and the more deeply he becomes involved in it, the more disastrous is his isolation. Sin wants to remain unknown. It shuns the light. In the darkness of the unexpressed it poisons the whole being of a person.[5]

Those church members who want to involve themselves in half way services, must be prepared to listen to whatever feelings the former patients want to express. To do this the workers must be aware of the painful difficulty in admiting their own failures and fears. At the same time, the workers need to know that no matter how terrible their own feelings may seem, they are accepted by God. This honest acceptance of themsleves can then be felt by the patient. Robert Leslie, a professor of pastoral care at Pacific School of Religion in Berkeley, California, sees such an accepting relationship as one that can grow in a larger fellowship such as a church group.

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[4]Anton Boisen, The Exploration of the Inner World (New York: Harper&Brothers, 1936), pp. 267-268.

[5]Dietrich Bonhoeffer, Life Together (New York: Harper & Brothers, 1954), p. 112.

> It is not enough to present the challenge for finding the personal meaning in life;....A fellowship of accepting people is also needed, a fellowship that will stand by as hesitant and stumbling attempts are made to break away from meaningless routine and explore more meaningful patterns of relationships.[6]

A fellowship that provides the opportunity for a person to express his deeper feelings, helps the person move from a hidden sin to an outward confession. At the same time, it is a movement toward an atonement with one's God and fellow man. The church worker must be a strong enough person to allow the former patient express what he feels and still feel acceptance from the worker.

5. The attitude of tender, warm affection. It is difficult for some persons to show an affection that is warm and tender. Having offered such an affection, they have been rejected. They fear further rejection. Other persons, having been deprived of a tender and warm affection, feel uncomfortable about it. Many men, for example, have been taught that to be warm and tender is a feminine quality and not worthy of a man. Many men, therefore, feel guilt and shame in the presence of this affection.

A person who is tender and warm, however, acknowledges that all persons possess masculine and feminine traits. A person who shows warmth and tenderness is

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[6]Robert Leslie, Jesus and Logotherapy (New York: Abingdon Press, 1965), pp. 45-46.

acknowledging this affection as a gift from God. This affection is to be shared. If genuinely given, an affection that is tender and warm can draw people together in community. This is koinonia.

6. The attitude of feeling with the other person the feelings he is feeling about what he is feeling. For those who want to work in a half way service, there is a need to develop a sensitivity not only to what a person is saying but to what he is feeling. To the question, "How are you?" many persons respond, "Things are all right." People have learned this is an acceptable way to respond. It is safer and less open to rejection by an inquirer who doesn't really care. The feelings underlying this reply, however, may be tense with anger, loneliness or despair. In order to emphasize with these deeper feelings of the other, the church member needs to be aware of his own feelings. If these feelings are denied, then he who would relate to the former patient is dishonest and has no right to expect the former patient to share himself. The church member must be willing to risk himself and become more transparent. As Reuel Howe, a Protestant theologian, says:

> Everyone is a potential adversary of others, even those he loves. Only through dialogue are we saved from this enmity toward one another...One qualification is that it must be mutual and proceed from both sides and persist relentlessly.[7]

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[7]Reuel Howe, The Miracle of Dialogue (New York: Seabury Press, 1963), p. 3.

In this kind of relationship, a person is involved in the deeper feelings of another. This involvement neither dissects nor analyzes the other but instead confronts with him what he is facing and supports him with compassion.

7. The attitude of sharing yourself with the other appropriately with reference to what is going on within the other. In sharing oneself appropriately with another, there is always the possibility of receiving a cross of rejection. In this attitude those in a half way mission are called upon to accept the person even when they must disagree with some plan of action he may want to take. For example, a chaplain intern in training was told by his counselee that on his next visit home he would kill his wife. The chaplain intern reported this plan. After further investigation, it was found to be true. The action of the patient was not allowed to be carried out.[8] The patient was very angry with the intern for exposing this confidence. The intern, however, acted appropriately, for he recognized the patient did not have full comprehension of the consequences of his plan. As Goethe says: "If we take people as they are, we make them worse. If we treat them

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[8]This incident was shared at a clinical pastoral training meeting by one of the interns at Mendota (Wisconsin) State Hospital during the summer of 1959.

as if they were what they ought to be, we help them to become what they are capable of becoming."[9]

The half way service worker is called to accept the other and admit he is not so different. The worker also is to be true to himself and share his feelings when he feels that what is going on within the other is inappropriate to the other's healing.

These seven attitudes are related. Together they provide for a relationship that is genuine and healing. They are necessary foundations for any half way service that might occur between the former mental patient and the church member.

II. THE CHURCH IN A SUPPORTIVE RELATIONSHIP

The concern of this chapter is with ways the church fellowship can relate to the half way house movement. In the sections to follow, methods of direct participation by the church member in a half way service are enumerated. In this section a personal, but more indirect way of working with a particular service is stressed. This is the necessary and very important adjunct to a half way house program. It is a relationship of support to the soon-to-be released patient.

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[9]Johann Goethe: in Viktor Frankel, The Doctor and the Soul (New York: Knopf, 1955), p. 105.

Support during hospitalization. During hospitalization, the patient feels isolated from his community. Many of his relationships with those he felt were friends are now terminated. The patient needs support. He wants to know someone cares. At Patton State Hospital, a woman patient expressed the feelings of many other patients when she said: "It seems no one cares anymore. They neither write nor visit."

A church fellowship can support the patient by sending cards and letters. Personal visits can be made. A church group can be sponsor to a hospital unit and plan a monthly party. In this way the church group can bring some of the outside world into the patient's hospital world.

The church fellowship can also invite the hospital world to visit the outside community. During the summer of 1965, a small group of interested members of the Methodist Church in Palm Springs, California, invited the more healthy members of a male and female mental unit to spend a half-day in the Palm Springs community. They provided supper, games, and a tour of the city.

A later report by one of the unit personnel at Patton Hospital was: "The patients had such a good time and were so enthused about the trip that they have provided an incentive to work harder to get well among some of the less healthy patients in the unit." The church members themselves felt relaxed with the patients and found many of

their earlier anxieties about the mentally ill were unfounded.

A church fellowship can provide a supportive relationship to the patient's family. This can be done by visiting the family. From time to time a salad or dessert might be taken just to say the fellowship cares. Some of the church members might provide baby sitting while the spouse goes shopping or visits the hospital.

Some do's and don'ts. In supporting the person who has faced mental illness, some specific do's and don'ts are suggested by Lauren H. Smith, former chairman of the Council on Mental Health of the American Medical Association. His suggestions are:

1. Do...Give support, encouragement, respect and affection.
   Expect in general the same kind of conduct you would from anyone else.
   Be optimistic about the ability to change.
   Keep up the prescribed medicine.
   Set goals the patients can handle.

2. Don't...Be over solicitious or encourage dependency.
   Be demanding, disrespectful or rejecting.
   Threaten a return to the hospital.
   Agree with 'extreme talk' or attitudes.
   Talk behind his back.
   Try to fulfill all of the patient's needs by indiscriminate giving.[10]

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[10]Lauren H. Smith, "When a Mental Patient Comes Home," This Week (January 6, 1963).

These are various ways the church fellowship can provide support to the patient and his family. This supportive relationship is a very important appendage to involvement in a half way house service. By providing a bridge like relationship before the patient leaves the hospital it can make his adjustment easier upon his release.

III. THE INVOLVEMENT OF THE CHURCH FELLOWSHIP WITH COMMUNITY AGENCIES

The involvement of the church in half way services can benefit if some programs are undertaken in cooperation with other service agencies in the community.

Education. If the community can be educated and enlightened on the need for half way services, many services can be put into operation due to increased financial support and community participation. The greatest impact is usually made when the major service groups are united toward a common goal. The churches, schools, courts, businessmen, and social services can cooperate in a common task to discover the half way needs and the best use of resources at the specific time. The church can offer its building facilities for these planning meetings. The church can make its building facilities available to guest lecturers and as a place for volunteer training. At a later date, the church facilities may be used by a half way social club.

Legislation. The church can cooperate with other community organizations in legislative efforts to increase research, treatment facilities, and staff in the mental health field. The emphasis can be on prevention as well as aftercare for the emotionally troubled. The connection of the half way services with the hospital must not be overlooked. Some of the half way residents may have to return to the hospital. Community organizations must work together in requesting their elected representatives to provide a more adequate budget for the hospital as well as for half way services. The medical and nursing personnel at Patton State Hospital constantly felt the need for a more adequate drug supply to help the patients recover in a shorter period of time. The medical and nursing personnel also desired to see improved salaries to attract high caliber persons to the field of mental health.

Employment. In one employment study in the Boston area, thirty employees were interviewed in regard to their feelings toward working with a former mental patient. Of the thirty employees, twenty-eight expressed a willingness to work with a former patient.[11] The researchers have concluded from this study that the positive attitude of the

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[11]Simon Olshansky, Samuel Grob, and Irene T. Malamud, "Employer's Attitudes and Practices in the Hiring of Ex-Mental Patients," Mental Hygiene, XLII (July 1958), 398.

workers might be a source of support rather than an obstacle. They have also concluded that unions will need more guidance and leadership in the area of mental health.[12]

The community agencies can cooperate in the recruitment of employment possibilities for the skilled and unskilled former patients. It appears from the previous study that most co-workers will accept the ex-patient. Special credit can be given to those employers who are willing to forego some productivity in order to provide some half way employment service to the former patient.

A luncheon club in Michigan. It is illuminating by way of comparison to see the half way employment project adopted by a luncheon club for the qualified mentally retarded. This club adopted the project of uncovering a monthly quota of job openings in their city.

> Members were armed with effective presentations which they would show to potential employers wherever they met them-golf course, at lunch, in the course of business. The secret of the success of this project has been its modesty. The club set a reasonable monthly goal for itself-half-a-dozen openings, no more. Because of its reachable goal, the plan has gone on and on and on...not for months, but for years.[13]

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[12] Ibid., p. 400.

[13] Bernard Posner, "Jobs for the Mentally Handicapped." Washington: The President's Committee on Employment of the Handicapped, p. 8. (Mimeograph.)

The West Coast. Another illustration of the way an entire community can become involved in a half way employment service involves a community on the West Coast. This community agreed to an imaginative plan by a local mental hospital. The hospital believed in the work ability of the mentally restored. The hospital formed a panel of about fifty of the community's leading employers. Each month, three or four panel members were asked to visit the hospital and counsel patients on the verge of discharge. Their purpose was not to find specific jobs for the patients after their release. Their purpose was to give the patients advice about how and where to look for employment and to make their return to the community as smooth as possible.

The employers, in addition to educating the patients, were educating themselves. The education which consisted of regular hospital visits and extensive counseling, led the employers to discover the mentally ill were not a "strange breed." The employers began hiring ex-patients in larger numbers.

In fact, one employer hired a former patient four times. The patient had relapses. After each relapse his job was waiting for him.[14]

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[14]Ibid., p. 9.

IV. THE INVOLVEMENT OF LAYMEN IN ESTABLISHING A SHELTERED WORKSHOP

If the need for a half way service in the area of employment is recognized, a sheltered workshop may evolve out of this recognition. A small group of church members could be the impetus to organizing a workshop in the community. The organization and structure of such a workshop is provided in this section.

The plan and organization.[15] The recognition of the need for a sheltered workshop may occur to an individual or a group, such as a church study group. Following this recognition, other interested persons should be assembled to informally organize and plan future directions to be taken. This group should concern itself with a realistic inventory of community needs and a careful tabulation of the community resources available to aid in this inventory.

The resources available may consist of records and application lists from the local Office of Vocational Rehabilitation, the local Employment Service, the Mental Health Organization, and the nearby hospital. Supplementary information may be obtained from physicians, insurance

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[15]Percy J. Trevethan, "How Sheltered Workshops Are Established and Supported," Workshops for the Disabled. Rehabilitation Services Series, No. 371. Washington: Department of Health, Education, and Welfare.

groups, and employment agencies. If this information is carefully coordinated, a valid assessment will be made. This information then needs to be documented before being released to the community.

At this time, the committee should be greatly enlarged with representatives of the community. The initial committee should be willing to relinquish much of its power to the larger group to be formed. The initial sponsoring group can issue invitations to groups in the community such as educational institutions, social agencies, women's clubs, rehabilitation agencies, business groups, churches, labor unions, industries, television and radio stations, and the newspapers. The invitation should invite them as representatives and participants in further study and planning. Subcommittees for future programs, resources, facilities and leadership can be selected at this community wide meeting. A chairman who is dedicated and has the respect of the community should be selected at this meeting. The chairman must be a person who is willing and able to convert ideals into actualities.

It is important at this meeting to set forth the overall objectives of the sheltered workshop. Most community sponsored sheltered workshops should be non-profit. There will be high training and facility costs at first and any production profits will be low. Later the workshop may be self sustaining. The main objective, however,

should be training of the worker who needs this half way service, rather than profit. The workshop can be organized to serve those who will never be able to secure outside employment. It can also be organized to properly train the worker in preparation for normal employment in the community. Finally, the impression should not be created that this private sheltered workshop is a complete answer to the rehabilitation problem. The need for cooperation between the private and governmental workshops needs to be stressed.

Financing the workshop.[16] Most privately sponsored workshops are partially self supported and also subsidized. If the workshop serves only the high productive handicapped worker, the workshop may be self supporting. If the workshop is going to serve the less productive also, a subsidy is needed. This will be anywhere between five and forty per cent of the budget. A safe working formula places upon the community the responsibility for facilities and equipment, including replacements. Over and above this initial cost a continuing subsidy is secured from the local Community Fund, memberships and donations and fees for services performed. It is important to constantly review the budget. It is also important to have an annual audit of the budget.

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[16]Ibid., pp. 28-29.

Incorporation and board of directors.[17] If the sheltered workshop is incorporated, the individual members are absolved from personal liability. The incorporation also provides legal standing and therefore a prestige to the endeavor.

The Board of Directors must include representative interests. Depending upon the program and the kind of area to be served, between fifteen and thirty persons should be on the board. They are elected on a three year rotating basis though it should be possible to werve for a second term. Thereafter a one year period would have to intervene before the person is eligible for re-election.

The functions of the Board are to interpret and orient the public to the program, to establish financial policy and support, and to determine policy and program. The Board selects the "executive director" and evaluates the services and programs.

The Board may use "corporate members." Elected annually, these are between seventy-five to one hundred persons who are interested in the program and who pay nominal annual dues. They are allowed to vote on some of the programs as well as the annual budget. The use of these members provides personnel for committees, as well as eligible members for possible Board of Director membership.

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[17] Ibid., pp. 29-30.

Public relations program.[18] A workshop must inform the public about its needs and services. The public must be aware of the advantages to be derived from an organized community rehabilitation service. To do this, a public relations program is needed. The needs and services must be based on facts. There must be realistic short term goals which are moving toward long range goals. When possible, a specialized staff should be used for public relations.

Professional staff.[19] The professional staff consists of an executive director, director of operations, public relations director, personnel director and training director. Three qualities should be stated in the job analysis. They are the intellectual requirements, the needed skills for the job, and the physical demands of the task. The personnel should be matched against the job analysis for effective placement and promotion.

Personnel and worker standards.[20] In the hiring of personnel it is important to have a policy of application and employment practices, working conditions, hours of work, in-service training, and salary review. The holidays the workshop will recognize, the vacation periods, sick

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[18]Ibid., p. 30. [19]Ibid., p. 31. [20]Ibid., pp.31-3

leave policy and medical-health care should be clearly understood. Finally retirement provisions and termination procedures need to be defined.

In the hiring of workers, there must be a sense of stewardship and not exploitation. The caliber of the workers hired must not be determined by the cost involved but rather by their effectiveness in the program. The Federal and State Wage and Hour Regulations are to be observed. The materials produced by the workshop are to be acceptable standards of workmanship.

Finally adequate records must be kept. Besides monthly operating reports, annual audit by a certified public accountant should be made. Copies of the audit are to be sent to the Board of Directors and all other members.

V. THE INVOLVEMENT OF LAYMEN IN ESTABLISHING A HALF WAY RESIDENTIAL HOUSE

In San Francisco, California, four churches are cooperating in the establishment of a residential psychiatric half way house. In Berkeley, California, for over two years, a church has been supporting a half way house for young offenders released from prison. This section will explore the ways in which these churches became involved in organizing and supporting of residential half way houses.

Baker Place West

The information in this section on Baker Place West was for the most part obtained on April 7, 1966 in San Francisco in conversation with Mrs. Patricia Gumrukcu, a sociologist and consultant in the planning of Baker Place West. Due to the success of the half way program at Baker Place, a psychiatric residence, Patricia Gumrukcu and Rev. Lewis Durham, the director of Glide Urban Foundation, considered the organization of a second half way house. They recently presented their proposal to the San Francisco United Methodist Mission and received the agreement of financial support from the Methodist Mission. As the organization of the house is still in the planning stage, the name, Baker Place West, is used only as a tentative designation.

Recruitment of volunteers. In order to recruit lay volunteers from the Methodist Churches of San Francisco to be trained to participate in the organization of the new half way house, Lewis Durham and some members of the San Francisco United Methodist Mission spoke to Methodist ministers in the area and to church groups. Anyone interested was encouraged to enlist. Four Methodist churches responded. They were Pine, Hamilton, Trinity, and members from Park Presidio who were not involved in earlier training of Baker Place. There are nineteen lay people

presently enrolled in the program. They agreed to attend six sessions of training and one field trip to varied social agencies. The entire program of training encompassed a six week program. Each session lasted one and one-half hours.

Training of laymen. The training of the lay volunteers was held during March and April, 1966. It was conducted by Price Cobbs, a psychiatrist, and Patricia Gumrukcu. They were assisted by a Methodist district superintendent, volunteers who were working at Baker Place, the resident managers of Baker Place, a social worker, and Lewis Durham, the director at Glide Foundation. Each session began with a lecture and concluded with a discussion.

The first training session consisted of an introductory lecture on the emotional and social adjustment problems of a former patient. The purpose of a half way house and the kind of house proposed for Baker Place West was included in this lecture. The volunteers were told that present plans call for a house to serve post hospitalized mental patients between the age of eighteen and forty-five years of age. Baker Place West will also accept young adults with social adjustment problems such as homosexuality and pregnancies out of wedlock.

Young adults, who are new to the community and are seeking a place to live, are also accepted for residency and are categorized as non-referrals. These young adults

have their own particular social problems, but they are able to cope with them.

Following the lectures, there was a discussion on the method used in screening applicants for residency. One criterian used is the patient's motivation to develop stability in terms of self care via employment or schooling. The second criterian is whether the applicant can handle his behavior appropriately in a group setting.

The second session dealt with the organization of people in the half way house. The relationships and communication between staff, volunteers, non-referrals, and patient-residents was stated. A discussion period followed. The emphasis was upon the volunteer as a listener and supporter to the resident in helping the resident make decisions. The volunteer was told to assist the resident instead of telling him what to do or doing it for him. The volunteer was told to refer the resident to the appropriate staff member if questions of employment or schooling arose. The same suggestion was made if the resident had a complaint toward a specific staff member. Dr. Cobbs and Mrs. Gumrukcu role played various situations the volunteers might encounter in their service to the residents.

The third session was devoted to the church and the community. It was led by two ministers. One emphasis was upon the motivation behind the volunteers' desire to serve.

A second emphasis was upon what the volunteer can expect to give and get in his service with the resident-patient. Two volunteers at Baker Place shared their personal experiences.

The fourth session dealt with the role of the resident-managers. This session was led by the two managers at Baker Place. They shared a typical day at Baker Place. They told how they dealt with emergencies such as attempted suicide. They stressed the importance of obtaining help rather than giving antidotes. They spoke of checking locked doors to be sure the residents were all right. Especially important to notice was an extreme change in the patient's behavior. A summary of some signs of mental illness to be noticed by the volunteers who plan to work at this new half way house are listed as:

1. Any sudden change in mood or personality so the person looks entirely different than he did before.
2. The development of new symptoms, as the sudden hearing of voices.
3. The beginning of a delusional system (false beliefs).
4. The beginning of illusions (reality based, but victim adds onto it).
5. A sudden development of psychosomatic preoccupation (he feels he has cancer).
6. He becomes extremely nervous and anxious.
7. There is a great mood swing in the direction of depression (difficulty in talking, thinking, and movement).
8. Suicidal gestures or thoughts.
9. Sudden change in reality, as loss of a job, or family problems.
10. The stoppage of medication or counseling appointments.

11. The changing of roommates or house friends.
12. The sudden withdrawal from other people and activities.[21]

The resident managers, as well as Mrs. Gumrukcu and Dr. Cobbs then entered into a discussion with the volunteers.

The fifth session was led by a staff member with the Bureau of Social Work. She listed the services provided to the residents by other agencies and the expectations of the half way house by other social agencies. A field visit to a day treatment center and a rehabilitation workshop was planned for the following week.

The sixth session began with a discussion of the recent field visit. A summary of the different kinds of volunteer service to be provided was presented. This included the volunteer as a listener and supporter to the resident. The volunteer also saw his role as taking telephone messages, showing visitors through the home, and alerting the staff to specific problems of individual residents. This final session ended with a tour of Baker Place.

After the volunteers have undergone six sessions of training some screen themselves out of the program. As soon as more permanent organizational plans are formulated, those volunteers who want to further involve themselves

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[21]Price Cobbs, "Psychotherapy and Practical Help," in Glide Urban Foundation, Specialized Housing for Young Adults (San Francisco, 1964), pp. 35-37.

in the program help furnish the house and then prepare to serve the incoming residents. This is one way a group of churches have become involved in a half way residential house.

Howard House

It is illuminating by way of illustration to see how the First Congregational Church of Berkeley, California, organized a half way residence for teen age juvenile offenders recently released from prison. The following information was obtained on April 7, 1966 in Berkeley, California in conversation with the Rev. Fred Strasburg, associate pastor of this church.

The influence. In the Fall of 1960, Larry Balch, a theological student who had formerly been in prison, met with a mother whose son was in prison. They formed a group called the "Allied Fellowship" in Oakland, California. Its purpose was to provide a half way residence for former prisoners. Enlisting financial aid from the area churches, the group incorporated in the Spring of 1961. A half way residence called Fellowship House was formed.

In January of 1962, the work of the Allied Fellowship was made known to the Board of Trustees at First Congregational Church in Berkeley, California. The trustees allocated money for this project. Some of the trustees

visited the meetings of the Allied Fellowship. A few became members of their board.

In the Fall of 1962, members of the First Congregational Church became very concerned about community outreach. Community racial problems forced some members to openly admit they felt the church was irrelevant. At this time the senior pastor, Dr. Browne Barr, was working on a series of lectures he was to give at Yale University in the Spring of 1963. His theme was the church scattered and dispersed. Out of this research experience grew the feeling that he wanted to further explore this area with his own fellowship. He used the church newsletter, monthly church meetings and special emphasis days to stress this concept of the dispersed church.

Organization in the church. At one of the official Board meetings, a trustee suggested an open ended budget. This meant there would be no limit on the amount of money the church would raise for its total budget. The goal of the budget would go beyond the needs of the local congregation. This open ended budget led to an open ended fund. All special offerings, such as those taken at Easter and Christmas, would be placed into this fund.

A "Directors of Parish Projects" group was suggested by the senior and associate pastors. By a vote of the church membership, the "Parish Projects" group was formed.

The group consisted of one representative each from the Mission, Social Concerns, Deacons, and Interracial Understanding Committees. Six members from the parish at large were also selected for this group.

This group was charged with the use of the finances in the open end fund. The finances came to about $7,000 over a two and one-half year period. The prevention of duplication of projects among the various committees concerned with community outreach was another function of this group. Finally the group was charged with seeking new projects in which personal talent and the finances from the open end fund could be used.

In the Fall of 1963, a parole agent for the California Youth Authority spoke to Dr. Barr. The parole agent worshipped at the church and was aware of Dr. Barr's interest in the Allied Fellowship. He told Dr. Barr that the Youth Authority wanted private agencies to sponsor half way residential houses. It was felt private agencies could provide closer contacts with the police and influential people of the community than a state agency.

The pastors of the church met with the members of the "Parish Projects" committee. The half way house project was considered a worthwhile possibility. A sub-committee was set up to study the proposal in greater detail. After more detailed study, the sub-committee

reported a favorable verdict but felt a final decision should include the entire membership. At a special all church meeting the plans were presented. They were approved. The "Parish Projects" committee notified the state of this approval. The church was told the state had cancelled its plans.

In the Fall of 1964, the "Parish Projects" committee was notified that the state had reconsidered their previous plans and would provide $2,500 per month for the half way house. The boys the Youth Authority would send were to be between eighteen and twenty-three years of age. A special "Half Way House Committee" of twelve members was then organized by the church. It consisted of most of the members of the "Parish Projects" committee plus other handpicked persons who showed an interest in this project. From time to time, persons with special skills are invited to take part in committee plans and decisions. This new "Half Way House Committee" set up sub committees dealing with finance, housing, staff and program. When Howard House was incorporated in 1965 the members of this "Half Way Committee" became members of the Board of Directors.

Finance. The committee on housing obtained from the California Youth Authority a financial commitment of $2,500 per month. The church board agreed to use the open end fund from Christmas and Easter offerings to support this

house. This has been about $3,000 per year. Personal donations from the church fellowship have furnished the house.

Housing. The committee on housing sought an older home that had a warm, homey atmosphere. They selected one that had a central location near shopping and transportation facilities. The home is also near the library and Y.M.C.A. A few of the men in the congregation were planning to purchase the home and lease it to the church. Before signing the contract, another purchaser tried to obtain the house. In conversation with him, an agreement was reached whereby he would purchase the house and lease it to the church.

A meeting with the leaders in the city government was called before signing the lease. The police chief, city planner, and building inspector met with the Board of Directors. The purpose of this meeting was to create goodwill by informing the city government about the project and have them respond. The police department, the city government, and the church have since been in close cooperation. After this meeting, the lease was signed and the home received its first residents on June 1, 1965.

Staff. The committee on staff advertised in church publications throughout the nation. In response to this,

a young married couple from out of state was finally hired to become resident managers. They were both teachers. The husband taught at a penitentiary. A few months after their arrival, there developed a great amount of friction between the resident managers and the boys who came from the prison. After an investigation, the Board of Directors concluded the couple had been very rigid and attempted to force their way of life upon the youth-residents. The resident managers had difficulty accepting the youths as they were and expected a complete change of attitude in one month. The Board of Directors also concluded the couple had little privacy and this contributed to the friction. The Board of Directors finally discharged the couple.

From this experience the Board decided to hire only a single man as a resident director. They also decided to hire a residential director on a one month trial basis. If this proves to be satisfactory, he will be hired for a longer period of time. The vocational training of the resident manager is considered to be of less importance than his ability to accept the paroled youth. All applicants for the position of resident director are now interviewed personally. There are also four program assistants working in the home. Each is hired for one month on a trial basis before being hired for a longer term. Two of these men live in the home. The other two spend about fifteen hours

in the home per week. These assistants are students at nearby colleges. Their function is to relate to the paroled youth on a one to one basis. Members of the First Congregational Church cover the house when some of the staff must be away. There are presently five youth in the house. The house has a capacity for ten youth.

Besides the non-professional staff of resident director and program assistants, the staff consists of a part time social worker and a part time parole agent from the Youth Authority. They provide personal and vocational caonseling with the boys. They also screen prospective young people for residency.

Program. This program has little structure. There is a weekly therapy session led by the social worker and parole agent. Each paroled resident must attend. On Saturdays, each resident has mandatory jobs to do such as yard work or house cleaning. Each youth must become self supporting as soon as possible. After 90 days he must leave the house. A cook was hired to provide the evening meals. The boys provide the rest of their meals. A few parties have been planned but a more structured recreational program has not been effective.

The church members are not too active personally in the program. One reason is that some church members have been used by the boys who have run up large telephone bills

and misused the church members' cars. Some of the church fellowship are, therefore, afraid and wary of personal involvement. Another reason is due to the youth residents themselves who resent the invasion of their privacy by church members.

Presently, some church members are involved in making donations of furniture and providing a few parties for the youth. Some members cover the house when the staff is away. The Board of Directors of the church spend a great amount of time in policy matters as well as discussions with the house staff.

Problems. This half way house project illustrates some of the problems encountered by one church. Through experience they have learned the importance of hiring staff through personal interviews rather than telephone conversations. It is the personality of the staff, not the respective career he is following that is important to the church in their hiring of personnel.

The Board of Directors feels that another problem that needs correction is the lack of enough depth therapy sessions among the youth. The Board feels many of their decisions are limited by the Youth Authority. The Youth Authority wants to phase out the social worker. They feel the emphasis should be on immediate problems such as employment. The Youth Authority feels ninety days is too

little time to provide depth therapy. At the same time, however, the Youth Authority does not want any boy to remain in the house longer than the ninety day limit. The Board of Directors would like the limit of stay lengthened to one year. Many hours are spent between the Board of Directors of the church and the Youth Authority in regard to this matter. This is one problem that arises when a church is subsidizing its projects from another agency, rather than fully supporting the project.

Conclusion. The organization of a half way residence by a church fellowship takes many hours of preparation. Once organized, many problems continue to arise and need correction. The First Congregational Church in Berkeley, California is honest in admitting it has made mistakes and has some tough problems to tackle.

They do not intend to give up the program. First of all they hope that through continued discussion with the Youth Authority the program in the house can be improved. A second reason is their Christian motivation in providing a place where the boys know they are welcome. The church fellowship wants the youths to succeed. They want the project to be a success.

The primary purpose for the house, however, was expressed by Rev. Strasburg when he said:

> From the beginning, our main purpose as a church was to be available and accepting of the boys at this crucial stage of their life. Even though they are antagonistic and rebellious, we want them to know we are here for them. This purpose will continue.

Many members of the church seem to be motivated to serve in a half way mission. However, they also seem to lack certain tools.

The progress of this house could be helped if a longer residency stay is obtained for the youths. This would allow for depth therapy on a feeling level rather than the present immediate problem level of employment and schooling. The church should also consider the part time hiring of a psychiatrist trained in penology who could provide this therapy in greater depth and act as a consultant to the staff and resident-youths.

The psychiatrist could also work more closely in training the laymen how to work with these youth. This would provide more lay understanding of how to adequately respond to the youth and less chance of being manipulated by the youth. This could lead to wider personal lay involvement.

VI. CONCLUSION

This chapter began with the importance of understanding one's motivation for working in the half way house movement with former mental patients. Seven attitudes were

listed. The statement was made that the more a church member understands these attitudes within himself and is able to share them with the former patient, the more meaningful will be the relationship.

The next section listed ways in which the church could be a supportive relationship to the soon to be released patient and to his family. This relationship was seen as an important adjunct to direct involvement in a half way house program. It provided a bridge to the half way house services and community before the patient's release.

The following sections of this chapter listed suggestions for organizing various forms of half way services. Illustrations were given of the way other churches or groups had planned and organized half way services.

CHAPTER VII

CONCLUSION

The half way services provide valuable and necessary assistance to the former hospitalized mental patient. After release from the hospital, the patient experiences an insecurity and difficulty in attempting to integrate and establish himself as a member of the community. Half way services aid the former patient in this tenuous transition into the community by providing facilities that offer an informal, warm, and supportive environment.

The church fellowship can be a vital force in stimulating the community to take a more positive attitude toward the released mental patient. The church fellowship can be the impetus that unites the community in realizing its responsibility to provide half way services to the released patient.

In order to do this, the church fellowship must first be aware of the fixed concepts of mental illness that imprison creativity and experimentation. Throughout history, a few persons could be found who would not be limited by the narrow concepts of mental illness in their society. It was not until the 20th century, however, that the concepts of mental illness were radically changed. The rise of the psycho-therapeutic sciences has been one of the main

contributing factors to this rapid change. These sciences have been effective in changing the community attitude to a more positive outlook on mental illness. The mentally ill are now seen as curable, rather than hopeless. This concept of hope in the mental health field has led to a realization that half way services are a necessary part of any mental health program.

A variety of half way services are being formed, such as social clubs, day care centers, sheltered workshops, and residential houses. Some of these are secular, while others are religiously inspired. The church fellowship can be a pioneer in the community by encouraging and expressing these new concepts of half way services which provide new hope for the mentally ill. In this area of service, the church fellowship is responding to the challenge of her Lord who calls them to shape their mission around the world's needs.

Secondly, for church workers to be effectively involved in a half way service, success must be seen in terms of the former patient's individual growth. In this way success will not be determined by a preconceived notion of how quickly someone else has recovered and has become involved in full community responsibility.

The worker can be most effectively involved in half way services when he understands his own personal dynamics.

He will then be slower to judge and better able to empathize with the former mental patient. The worker will be able to see things more clearly from the former patient's frame of reference. In April, 1966, Hospitality House, a retreat center in San Francisco sponsored by Glide Urban Foundation, had a saying posted on a wall which expresses this need for empathy. It said: "O Lord, before judging any man, let me first walk in his shoes for two weeks."

The half way service movement is a young movement. It is an area of challenge and exploration. The future of half way services will depend upon the continuing creative vision of persons concerned about their fellow man. The future effectiveness of half way services will depend upon persons committed to discovering new and improved half way services. The future growth of half way services will depend upon persons who will persevere in spite of obstacles that occur. Long ago, a challenge was given to all men by one who said:

> For he is our peace, who has made us both one and has broken down the wall of hostility, by abolishing in his flesh the law of commandments and ordinances, that he might create in himself one new man in place of the two, so making peace, and might reconcile us both to God in one body through the cross, thereby bringing the hostility to an end.
> (Ephesians 2:14-16)

A poet responded to this challenge by saying:

He drew a circle that shut me out-
Heretic, rebel, a thing to flout.
But love and I had the wit to win,
We drew a circle that took him in![1]

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[1]Edwin Markham, The Shoes of Happiness, (Garden City: Doubleday, 1928), p. 1.

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